External Quality Review

Calendar Year 2021

Annual Technical Report

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

Final Report

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Prepared by

METASTAR

April 19, 2022

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EXECUTIVE SUMMARY

EXTERNAL QUALITY REVIEW PROCESS

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans and managed care organizations, including BadgerCare Plus, Supplemental Security Income, Foster Care Medical Home, Children Come First, and Wraparound Milwaukee, to provide for external quality review of these organizations and to produce an annual technical report. To meet its obligations, the State of Wisconsin, Department of Health Services (DHS) contracts with MetaStar, Inc. Review activities are planned and implemented according to The Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols.

This report covers the external quality review calendar year from January 1, 2021-December 31, 2021 (CY 2021). Mandatory review activities conducted during the year included assessment of compliance with federal standards, validation of performance measures, validation of performance improvement projects, and information systems capabilities assessments. MetaStar also conducted one optional activity, conducting focused studies of health care quality - care management review. Care management review assesses key areas of care management practice and also supports assessment of compliance with federal standards.

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, HIV/AIDS Health Home, and Obstetric Medical Home. Reviews for these programs evaluated the practices and requirements related to care coordination/care management.

SCOPE OF EXTERNAL QUALITY REVIEW ACTIVITIES

Protocol 1[1]: Validation of Performance Improvement Projects

Validation of performance improvement projects is a mandatory review activity, required by 42 CFR 438.358, and is conducted according to federal protocol standards. CMS issued the EQR Protocols in 2020 and *Validation of Performance Improvement Projects* is now Protocol 1. To evaluate the standard elements of a Performance Improvement Project, the MetaStar team used the methodology described in the CMS guide, EQR Protocol 3: *Validating Performance Improvement Projects (PIPs), A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0,* as this was the Protocol in effect during the project timeframe. The purpose of a

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

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.

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.

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

An assessment of compliance with federal standards, or a quality compliance review, is a mandatory activity, identified in 42 CFR 438.358, and is conducted according to federal protocol standards. Compliance standards are grouped into three general categories: Managed Care Organization Standards; Quality Assessment and Performance Improvement; and Grievance Systems.

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 (NCQA) Health Plan Accreditation, MetaStar identified gaps between the sets of requirements. Managed Care Organizations (MCO) 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 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.

Care Management Review – Foster Care Medical Home

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

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

Appendix V: Information Systems Capabilities Assessment

An assessment of a MCO'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.

Optional Reviews: Other Medicaid Programs

Record Review – Children with Medical Complexities

Children with Medical Complexities is a target group covered under the Medicaid-targeted case management benefit. It is administered fee-for-service for all Medicaid-enrolled members who demonstrate medical necessity for covered services. The benefit is separate from managed care organizations and 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 – HIV/AIDS 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 (HIV) and at least one other chronic condition, or be at risk of developing another chronic condition. The health home provider is accountable for the total care of the member, using a patient-centered model, which includes a care team working with the member to meet his/her medical, dental, behavioral health, pharmacy, care management, and social service needs.

This review was conducted in CY 2021, but the results are not finalized and the report has not been issued. Results from this optional activity will be reported separately once they are finalized.

Record Review – Obstetrics Medical Home/Healthy Birth Outcomes

The Obstetrics Medical Home (OBMH) initiative was established in 2011. The OBMH is a patient-centered, comprehensive, coordinated, and team-based care delivery model, focused on reducing poor birth outcome disparities. A key component of the OBMH 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 2021, 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 MCOs, based on compliance with specific requirements detailed in the DHS-MCO contract. Due to the timelines associated with this retrospective review, the results of this optional activity are reported separately.

Analysis: Quality, Timeliness, Access

The table below highlights the assessments of quality, timeliness and access to health care services conducted through each review activity. Compliance with these review activities provides assurances that the state is meeting requirements related to access, timeliness, and quality of services, including health care and long-term services and supports. State level findings of strengths, progress, and recommendations to address weaknesses are included. Additionally, different aspects of the State's *2021 Medicaid Managed Care Quality Strategy* supported by the review activities are identified.

<table>
<tr><th>Quality</th><th>Timeliness</th><th>Access</th><th colspan="2">Strengths, Progress, and Recommendations and The State Quality Strategy</th></tr>
<tr><td colspan="5">Protocol 1: Validation of Performance Improvement Projects</td></tr>
<tr><td rowspan="7">√</td><td rowspan="7">√</td><td rowspan="7">√</td><td colspan="2">STRENGTHS</td></tr>
<tr><td><u>Review Findings</u></td><td><u>The State Quality Strategy</u></td></tr>
<tr><td>Project topics focused on improving key aspects of care for members.</td><td>Improve member engagement and experience of care.
Improve access to behavioral health care.
Implement delivery system reform strategies to improve transitions of care.
Reduce health disparities, improve cultural competence, encourage cross-sector partnerships to improve the drivers of health in Wisconsin.</td></tr>
<tr><td>The most successful projects developed approaches to monitor the effectiveness of interventions, by conducting continuous cycles of improvement and ensuring data collection processes were sound.</td><td>Ensure continuous improvement of high-quality programs to achieve member’s identified goals and outcomes.</td></tr>
<tr><td>Knowledgeable, qualified teams were selected to conduct the projects.</td><td>Build collaborative relationships with both internal and external stakeholders and partners.</td></tr>
<tr><td>Follow-up actions for further improvement were identified as the result of data analysis.</td><td>Ensure continuous improvement of high-quality programs to achieve member’s identified goals and outcomes.
Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.</td></tr>
<tr><td colspan="2">PROGRESS</td></tr>
<tr><td><u>Review Findings</u></td><td><u>The State Quality Strategy</u></td></tr>
</table>

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
			One standard continued to be met at 100.0 percent and improvement was noted in 12 additional standards in CY 2020.	Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.
			Overall, the percentage of applicable standards met improved to 86.1 percent in CY 2020, from 80.3 percent in CY 2019.	Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.
			MCOs addressed recommendations related to the study topic, study question, indicators, data analysis, and real improvement.	Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Address cultural and linguistic appropriateness of interventions.	Improve health equity and reduce health disparities through culturally competent practices and policies.
			Ensure initial and repeat measures are comparable to assess improvement in desired outcomes.	Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.
			Take study limitations into consideration in analysis.	Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.
			Conduct analysis to determine reasons for less than optimal improvement.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.

<table>
<tr><th>Quality</th><th>Timeliness</th><th>Access</th><th colspan="2">Strengths, Progress, and Recommendations and The State Quality Strategy</th></tr>
<tr><td colspan="5">Protocol 2: Validation of Performance Measures Validation</td></tr>
<tr><td rowspan="8">√</td><td rowspan="8">√</td><td rowspan="8">√</td><td colspan="2">STRENGTHS</td></tr>
<tr><td><u>Review Findings</u></td><td><u>The State Quality Strategy</u></td></tr>
<tr><td>Timeliness of Prenatal Care.</td><td>Provide access to primary care and preventive services to maintain wellbeing, identify health concerns, and ensure timely intervention.

Reduce health disparities, improve cultural competence, encourage cross-sector partnerships to improve the drivers of health in Wisconsin.</td></tr>
<tr><td colspan="2">PROGRESS</td></tr>
<tr><td><u>Review Findings</u></td><td><u>The State Quality Strategy</u></td></tr>
<tr><td>Due to newly identified measures from the previous period progress could not be measured.</td><td>Not applicable</td></tr>
<tr><td colspan="2">RECOMMENDATIONS</td></tr>
<tr><td><u>Review Findings</u>

Facilitate Childhood Immunizations.

Improve Postpartum Care.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.</td><td><u>The State Quality Strategy</u>

Provide support to manage chronic conditions and reduce adverse acute outcomes.

Provide access to primary care and preventive services to maintain wellbeing, identify health concerns, and ensure timely intervention.

Promote early intervention for substance use and timely follow-up care for behavioral health concerns.</td></tr>
</table>

<table>
<tr><th>Quality</th><th>Timeliness</th><th>Access</th><th colspan="2">Strengths, Progress, and Recommendations and The State Quality Strategy</th></tr>
<tr><td colspan="5">Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review</td></tr>
<tr><td rowspan="7">√</td><td rowspan="7">√</td><td rowspan="7">√</td><td colspan="2">STRENGTHS</td></tr>
<tr><td><u>Review Findings</u></td><td><u>The State Quality Strategy</u></td></tr>
<tr><td>Strong systems are in place to help members understand their rights as well as ensuring those rights are protected.</td><td>Provide access to primary care and preventive services to maintain wellbeing, identify health concerns, and ensure timely intervention.

Improve member engagement and experience of care.</td></tr>
<tr><td>MCOs demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers.</td><td>Reduce health disparities, improve cultural competence, encourage cross-sector partnerships to improve the drivers of health in Wisconsin.</td></tr>
<tr><td>MCOs demonstrated the ability to ensure coordination and continuity of member care.</td><td>Implement delivery system reform strategies to improve transitions of care.</td></tr>
<tr><td>MCOs have the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement.</td><td>Ensure continuous improvement of high-quality programs to achieve member’s identified goals and outcomes.</td></tr>
<tr><td colspan="2">PROGRESS</td></tr>
<tr><td><u>Review Findings</u></td><td><u>The State Quality Strategy</u></td></tr>
</table>

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
			MCO's with a previous Compliance with Standards review addressed 55.8 percent of the recommendations from the prior review in CY 2018. - Improvements were related to enrollee rights, provider network adequacy standards, and quality assessment and performance improvement activities. - One PIHP continued to have grievance systems recommendations, and only met 34.6 percent of the grievance systems standards in CY 2021.	Improve member engagement and experience of care. Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Issue notices of adverse benefit determination when indicated and within contract specified timeframes to ensure members are able to exercise their rights.	Promote and protect the human and legal rights of program beneficiaries. Improve member engagement and experience of care. Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.
			Ensure providers receive information regarding member grievance and appeal rights.	Promote and protect the human and legal rights of program beneficiaries. Improve member engagement and experience of care. Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
			Implement processes to ensure services are started, reinstated, or payments are made for services when appeal decisions are reversed.	Promote and protect the human and legal rights of program beneficiaries. Improve member engagement and experience of care. Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.
Protocol 9: Conducting Focused Studies of Health Care Quality-Supplemental Security Income Program				
√	√	√	**STRENGTHS**	
			Review Findings	The State Quality Strategy
			No state level findings of strengths identified.	Not applicable
			PROGRESS	
			Review Findings	The State Quality Strategy
			Care plan development occurred with the member.	Provide person-centric care through needs stratification, integration of social determinants, person-centric care plans, interdisciplinary care teams, and an on-going assessment and alignment of the members' needs with their care.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Improve comprehensiveness of screening by ensuring assessment of the members' perception of strengths and general well-being.	Provide person-centric care through needs stratification, integration of social determinants, person-centric care plans, interdisciplinary care teams, and an on-going assessment and alignment of the members' needs with their care.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
			Ensure the completion and documentation of evidence-based care plans, including identifying interventions at the time of care plan development that are sequenced and meet member needs.	Provide support to manage chronic conditions and reduce adverse acute outcomes. Provide access to primary care and preventive services to maintain wellbeing, identify health concerns, and ensure timely intervention.
			Provide timely post-hospitalization follow-up with members.	Provide access to primary care and preventive services to maintain wellbeing, identify health concerns, and ensure timely intervention.
			Continue efforts to assist organizations in reducing health disparities and improving engagement for members' care and experience.	Improve health equity and reduce health disparities through culturally competent practices and policies.
			Consider increased monitoring of post-discharge follow-up and use of the *Wisconsin Interdisciplinary Care Team* level of service to help mitigate potentially preventable re-hospitalizations.	Provide support to manage chronic conditions and reduce adverse acute outcomes.
Protocol 9: Conducting Focused Studies of Health Care Quality-Foster Care Medical Home				
√	√	√	**STRENGTHS**	
			Review Findings	The State Quality Strategy
			Completion and comprehensiveness of the health screens.	Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values.
			Timeliness of Initial HealthCheck assessments	Promote early intervention for substance use and timely follow-up care for behavioral health concerns.
			Follow through of coordinating the service needs identified during the Initial HealthCheck assessment.	

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
			Timeliness of care plans.	Provide access to primary care and preventive services to maintain wellbeing, identify health concerns, and ensure timely intervention.
			PROGRESS	
			Review Findings	The State Quality Strategy
			Completion of comprehensive care plans.	Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Continue efforts to assist the PIHP in identifying and reducing health disparities.	Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values. Provide support to manage chronic conditions and reduce adverse acute outcomes. Provide access to primary care and preventive services to maintain wellbeing, identify health concerns, and ensure timely intervention.
			Assist the PIHP in updating its process for updating care plans to ensure ongoing identification and timely intervention of member conditions to maintain each member's wellbeing.	
			Communicate the service needs identified in the health screen to all required team members.	
			Create comprehensive care plans.	
			Conduct all monitoring activities.	
			Complete transitional health care planning.	
			DHS should consider evaluating the effectiveness of the pilot model to ensure contractual requirements are met by the PIHP.	
Appendix V: Information Systems Capabilities Assessments				

<table>
<tr><th>Quality</th><th>Timeliness</th><th>Access</th><th colspan="2">Strengths, Progress, and Recommendations and The State Quality Strategy</th></tr>
<tr><td rowspan="11">√</td><td rowspan="11">√</td><td rowspan="11">√</td><td colspan="2">STRENGTHS</td></tr>
<tr><td><u>Review Findings</u></td><td><u>The State Quality Strategy</u></td></tr>
<tr><td>The organizations demonstrated all-encompassing internal systems that are maintained and updated by a stable and experienced information system department.</td><td rowspan="4">Ensure timely access to complete and accurate health data.

Evaluate data systems to ensure they effectively support programs and strategies in collecting relevant and adequate clinical and other data from multiple sources.

Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.</td></tr>
<tr><td>Robust ongoing training programs to ensure all Medicaid data is processed accurately and within the expected timeframes.</td></tr>
<tr><td>The security systems meet or exceed most industry standards, ensuring consistent system and data availability.</td></tr>
<tr><td>The processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter data is provided to the state.</td></tr>
<tr><td colspan="2">PROGRESS</td></tr>
<tr><td><u>Review Findings</u></td><td><u>The State Quality Strategy</u></td></tr>
<tr><td>Remedied the challenges and improved the process related to ensuring the accuracy of claims data and encounter files.</td><td rowspan="3">Ensure timely access to complete and accurate health data.</td></tr>
<tr><td>Successfully developed and implemented a disaster recovery plan.</td></tr>
<tr><td>Automated and formalized processes for updating the provider directory and validating data entry.</td></tr>
<tr><td colspan="2">RECOMMENDATIONS</td></tr>
</table>

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
			Review Findings	The State Quality Strategy
			Ensure implementation of the *Federal Information Processing Standards* compliant software, including testing requirements.	Ensure timely access to complete and accurate health data.
Non-Managed Care Programs – Children with Medical Complexities				
√	√	√	**STRENGTHS**	
			Review Findings	The State Quality Strategy
			Eligibility requirements.	Not applicable
			Timely and comprehensive assessments.	
			Timeliness of care planning.	
			PROGRESS	
			Review Findings	The State Quality Strategy
			No progress was identified at the state level; however, most measures maintained above 90 percent compliance from year-to-year.	Not applicable
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Improve the comprehensiveness of care plans by including goals that are specific, measurable, achievable, relevant and timely.	Not applicable

Introduction and Overview

Acronyms and Abbreviations

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

Purpose of the Report

This is the annual technical report the Wisconsin Department of Health Services (DHS) must provide to the Centers for Medicare & Medicaid Services (CMS) related to the operation of its Medicaid managed health programs; BadgerCare+ (BC+), Supplemental Security Income (SSI), Foster Care Medical Home (FCMH), Wraparound Milwaukee (WM), and Children Come First (CCF). The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans and managed care organizations (MCOs) to provide for periodic external quality reviews.

In order to monitor compliance and quality related to the operation of other Medicaid programs, the DHS has requested record review for the following programs: OB Medical Home, HIV/AIDS Health Home, Children with Medical Complexities (CMC).

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, 2021-December 31, 2021 (CY 2021). See Appendix 2 for more information about external quality review and a description of the methodologies used to conduct review activities.

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

As of December, 2021 enrollment was as follows:

Program	Enrollment
BadgerCare Plus	**1,000,343**
Supplemental Security Income Medicaid	**60,232**
BadgerCare Plus Childless Adults	**235,967**
Prepaid Inpatient Health Plans	**1,030**
Foster Care Medical Home	**2,902**

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.

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)	BadgerCare Plus (BC+) Supplemental Security Income (SSI)	NCQA Medicaid Accreditation Expires: 10/11/2024 Multicultural Health Care Distinction Expires: 3/8/2023
Children's Community Health Plan, Inc. (CCHP)	BC+ FCMH	NCQA Medicaid Accreditation Expires: 12/18/2023 Exchange Accreditation Expires: 12/18/2023
Dean Health Plan, Inc. (DHP)	BC+	NCQA Commercial Accreditation Expires: 4/8/2022 Marketplace Accreditation 4/8/2022
Group Health Cooperative of Eau Claire (GHC-EC)	BC+ SSI	Accreditation Association for Ambulatory Health Care (AAAHC) Expiration Unknown
Group Health Cooperative of South-Central Wisconsin (GHC-SCW)	BC+	NCQA Commercial Accreditation 7/8/2022 Exchange Accreditation Expires: 7/8/2022
Independent Care Health Plan (*i*Care)	BC+ SSI	Not Accredited
MercyCare Health Plans (MCHP)	BC+	NCQA Commercial Accreditation Expires: 8/5/2022
MHS Health Wisconsin (MHS)	BC+ SSI	NCQA Medicaid Accreditation Expires: 9/6/2022
Molina HealthCare of Wisconsin (MHWI)	BC+ SSI	NCQA Medicaid Accreditation Expires: 4/10/2023 Exchange Accreditation Expires: 4/10/2023
My Choice Wisconsin (MCW)*	BC+ SSI	Not Accredited
Network Health Plan (NHP)	BC+ SSI	NCQA Commercial Accreditation Expiration Unknown
Quartz Health Solutions, Inc. (Quartz)	BC+	NCQA Commercial Accreditation Expires: 5/17/2022 Exchange Accreditation Expires: 5/17/2022

Managed Care Organization	Program(s)	Accreditation Organization and Status
Security Health Plan (SHP)	BC+	NCQA Medicaid Accreditation Expires: 5/8/2023 Commercial Accreditation Expires: 5/8/2022 Medicare Accreditation Expires: 5/8/2022 Exchange Accreditation Expires: 5/8/2023
United Healthcare Community Plan (UHC)	BC+ SSI	NCQA Medicaid Accreditation Expires: 2/11/2023
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

* In June 2019, the Office of the Commissioner of Insurance approved the purchase of Trilogy Health Insurance by My Choice Family Care (MCFC). In November 2019, DHS approved the merger of two separate MCOs, MCFC and Care Wisconsin (CW). The newly merged organization, My Choice Wisconsin (MCW), was approved to provide Medicaid managed care services through the BC+ and SSI programs in Wisconsin where CW and Trilogy, referred to as legacy MCOs, had previously provided SSI and BC+ services.

Organization	Program(s)
American Family Children's Hospital (AFCH)	Children with Medical Complexities
Children's Hospital of Wisconsin (CHW)	Children with Medical Complexities
Marshfield Children's Hospital	Children with Medical Complexities

Children with Medical Complexities is a benefit program separate from the managed care programs, and enrollment numbers are not publicly reported.

Analysis: Quality, Timeliness, and Access

The CMS guidelines regarding this annual technical report direct the EQRO to provide an assessment of each MCOs' strengths and weaknesses with respect to quality, timeliness, and access to health care services. The Medicaid MCOs and Prepaid Inpatient Health Plans (PIHPs) 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 tables below identify the mandatory review activities, scope of activities, and findings from the assessments of quality, timeliness, and access to health care services for the programs each MCO or PIHP operates.

Anthem	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 142,713 SSI: 7,934
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Composite Measure Improvement* • *PIP-Like Postpartum Care*	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - The study questions identified the focus of the projects and established the framework for data collection and analysis. - Appropriate sampling methods were utilized for both projects. - Knowledgeable, qualified teams were selected to conduct each project. Progress - The MCO addressed recommendations from CY 2019 by conducting and documenting continuous cycles of improvement. - Overall, the MCO met 80.0 percent of applicable standards in CY 2020, compared to 73.0 percent of applicable standards in CY 2019. Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for measurement year (MY) 2021. - One project should specify the data analysis plan. - Ensure the correct priority Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measurement year specifications are referenced and attached to the report for each measure. - The other project should ensure continuous cycles of improvement are conducted and documented, and that cultural and linguistic appropriateness of interventions are addressed.
Protocol 2: Validation of Performance Measures	Strengths - Lead Screening in Children. - Timeliness of Prenatal Care. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Improve Postpartum Care. - Ensure Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. - Facilitate Follow-Up after Hospitalization for Mental Illness. - Follow-Up after Emergency Department Visit for Mental Illness. - Coordinate Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment.

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

Anthem	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 142,713 SSI: 7,934
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.
	- The organization demonstrated the ability to ensure coordination and continuity of member care.
	- The organization has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement.
	- The organization has the structure and processes in place to provide a local system for grievances and appeals that also allows access to both DHS' grievances and appeals process, and the State Fair Hearing process.
	
	Progress
	- This is the first year of the review and therefore there is no progress to report.
	
	Recommendations
	- Update policies and procedures, the provider manual, and the member handbook to include:
	  o The length of time services will be provided to a member by an out-of-network provider; and
	  o As designated by the DHS-HMO contract the cost to the member for using an out-of-network provider would be no greater than it would be if the services were furnished by a network provider.
	- Revise the *Standards for the Number and Geographic Distribution of Practitioners – WI* policy to identify if providers have the capability to communicate with limited English proficient members in their preferred language when determining network adequacy.
	- Develop and implement a restraint policy and procedure.
	- Update the *Member Appeals – WI* policy to specify only one level of appeal at the MCO.
	- Update the provider onboarding and orientation process to ensure all providers receive the *Member Grievance and Appeals Guide* and *Ombudsman Brochure* as required.
	- Update the *Member Grievances* policy to ensure all required recordkeeping elements are retained for grievances and appeals.

Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review* *Sample Size: 100*	Strengths - The MCO had processes in place to complete screenings prior to care plan development. - Member care plans were reviewed and updated as required. - The MCO had processes in place to ensure members were restratified after critical events. Progress - Member needs were addressed by ensuring post-hospitalization follow-up requirements were completed. - Face-to-face member contacts were conducted and documented as required for the MCO's highest need members.

Anthem	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 142,713 SSI: 7,934
Findings	
	Recommendations - Update the care plan and associated processes to ensure the care plans are shared with the member and primary care physician (PCP) and include prioritization of goals. - Ensure outreach attempts meet the minimum frequency as identified by the MCO policy. - Ensure the WICT is well functioning by identifying the members of the WICT core team and ensuring the documentation demonstrates collaboration. - Complete and document comprehensive screenings that include the members' perception of their strengths and general well-being.
Appendix V: Information Systems Capabilities Assessments	Anthem is accredited by NCQA and as such is deemed by DHS as exempt from the ISCA review.

CCHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, FCMH	BC+:149,798 FCMH: 2,902
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Comprehensive Diabetes Care* • *PIP-Like Postpartum Care* • *Metabolic Monitoring (FCMH)*	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - The study questions identified the focus of the projects and established the framework for data collection and analysis. - The study indicators and study population were clearly defined for each project. - Appropriate sampling methods were utilized for all projects. - Analysis and interpretation of the data was based on a continuous quality improvement philosophy. - Knowledgeable, qualified teams were selected to conduct each project. - One project met all applicable standards. Progress - The project focused on diabetes care was a continuing project, in its second year of implementation. Quantitative improvement was not demonstrated in either year of the project, and the percentage of applicable standards met declined from 94.7 percent in CY 2019, to 78.9 percent in CY 2020. - The MCO addressed recommendations from CY 2019, and ensured each project conducted in CY 2020 specified a data analysis plan, and that the data was analyzed according to the plan. - Overall, the MCO met 88.2 percent of applicable standards in CY 2020 for the BC+ program, compared to 84.6 percent of applicable standards in CY 2019. The MCO met 100.0 percent of applicable standards in CY 2020 for the FCMH program, compared to 94.7 percent of applicable standards in CY 2019.

CCHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, FCMH	BC+:149,798 FCMH: 2,902
Findings	
	Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. - Two projects should describe how all data is collected. - One project should address cultural or linguistic appropriateness of all interventions, and select new interventions or modify ongoing interventions when performance is less than optimal for each year of a continuing project. - One project should continue to sustain the level of improvement that has been achieved.
Protocol 2: Validation of Performance Measures	Strengths - Lead Screening in Children. - Timeliness of Prenatal Care. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Facilitate Combo3-Childhood Immunization. - 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 has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement. Progress - This is the first year of the review and therefore there is no progress to report. Recommendations - Amend documentation to provide assurances that out-of-network requests for second opinions are available at no cost to the member. - Update the *Out of Network Policy and Procedure* to specify the length of time services will be provided to a member by an out-of-network provider, including the cost to the member for using an out-of-network provider would be no greater than it would be if the services were furnished by a network provider as designated by the DHS-HMO contract. Revise the *Member Enrollment and Disenrollment Exemption Policy and Procedure* to include the requirement to submit involuntary disenrollment requests with supporting evidence to the Department, as well as information regarding a change in a member's circumstance due to death or a move outside the MCO's service area. - Amend the *Timeliness of Utilization Management Decisions* policy and procedure to include the ability of a member or provider to request an extension to the standard and expedited decision-making timeframes. - Develop a policy and procedure for post-stabilization of care related to coverage and payment, specifying the medical professional responsible for

CCHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, FCMH	BC+:149,798 FCMH: 2,902
Findings	
	determining when the member is sufficiently stabilized for transfer or discharge. - Revise the *Practitioner and Organizational Provider Suspension, Termination and Appeal Rights* policy and procedure to address the requirement of immediately providing notification to the Department of any providers terminated from the network as a result of quality issues. - Develop and implement a policy and procedure to address the issuance of notices of adverse benefit determination when previously authorized services are reduced, terminated, or suspended. - Amend the *Timeliness of Utilization Management Decisions* policy and procedure to include the issuance of written notification of adverse benefit determinations to members as well as providers in the following circumstances: o When services are denied, terminated, reduced, or suspended; o When claims are denied; and o When the MCO is unable to make a decision on a service authorization request in a timely manner. - Revise the *Member Complaints Policy and Procedure* to address the provision of an initial response to the member within 10 business days of receipt of a grievance, and to provide assurances that the format of the grievance resolution notification letter that meets the standards described in the DHS *HMO and PIHP Communication, Outreach, and Marketing Guide.* - Update MCO documentation to specify that parties to an appeal may include a representative of a deceased enrollee's estate. - Amend the *Utilization Management Member Appeal Policy and Procedure* to include the following requirements: o The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner if possible; and o The requirement to authorize or provide disputed services as expeditiously as the member's health condition requires, but no later than 72 hours from the date the MCO receives notification that its appeals process or State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending.
Protocol 9: Conducting Focused Studies of Health Care Quality *FCMH Care Management Review* *Sample Size: 44*	Strengths - Completion and comprehensiveness of the health screens. - Timeliness of Initial *HealthCheck* assessments. - Follow through of coordinating the service needs identified during the Initial *HealthCheck* assessment. - Timeliness of care plans. Progress - Completing comprehensive care plans. Recommendations - Communicate the service needs identified in the health screen to all required team members. - Create comprehensive care plans. - Conduct all monitoring activities.

CCHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, FCMH	BC+:149,798 FCMH: 2,902
Findings	
	- Complete transitional health care planning.
Appendix V: Information Systems Capabilities Assessments	CCHP is accredited by NCQA and as such is deemed by DHS as exempt from the ISCA review.

DHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+: 47,824
Findings	
Protocol 1: Validation of Performance Improvement Projects • *PIP-Like Postpartum Care* • *Well-Child Visits*	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - The study questions identified the focus of the projects and established the framework for data collection and analysis. - The study indicators and study population were clearly defined for each project. - Knowledgeable, qualified teams were selected to conduct each project. - Appropriate sampling methods were utilized for both projects. - The organization was able to calculate a remeasurement rate for the project when the HEDIS measure was incorporated into a new measure. Progress - The PIP-like postpartum care project met all applicable standards in CY 2020. - Both projects conducted in CY 2020 clearly documented that the topic was selected through the organization's data collection and analysis of important aspects of member needs, care, or services, an improvement from CY 2019. - The percentage of applicable standards met declined from 86.5 percent in CY 2019, to 84.8 percent in CY 2020. Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. - One project should define the sources and processes of collecting data related to the implementation of interventions that occurred during the measurement year, conduct continuous cycles of improvement based on the review and analysis of data, and analyze data periodically as planned.
Protocol 2: Validation of Performance Measures	Strengths - Timeliness of Prenatal Care. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Ensure Lead Screening in Children. - Facilitate Combo3-Childhood Immunization.

DHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+: 47,824
Findings	
	- 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 has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement. Progress - This is the first year of the review and therefore there is no progress to report. Recommendations - Update policies and procedures, provider manual and member handbook to include: o The length of time services will be provided to a member by an out-of-network provider; and o As directed by the DHS-HMO contract, the cost to the member for using an out-of-network provider would be no greater than it would be if the services were furnished within the network. - Revise the *Dean Provider Manual* to include that network provider office hours may not be less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee for service if the provider only serves Medicaid enrollees. - Update the process for determining network adequacy to include consideration of the anticipated enrollment. - Develop and implement an enrollment and disenrollment process to include: o System-based disenrollment; o Involuntary disenrollment; o Change in member circumstances; and o MCO enrollment exemptions. - Develop and implement a restraint policy and procedure. - Revise the *Practitioner Credentialing and Recredentialing Procedure* and *Credentialing and Recredentialing Process for Organizational Providers Procedure* to include: o Assurance that providers serving high-risk populations or specializing in conditions with higher costs will not be discriminated against; and o Immediate notification to DHS when a provider is terminated for quality concerns. - Update the *Timeframe Standards for Medical UM Determinations – BC+* policy to include: o Notices for termination, suspension or reduction of previously authorized services or denial of payment are issued with the timeframes required by DHS. o Providing members written notice when a decision-making timeframe must be extended. - Revise the *Medicaid Grievance and Appeals – WI* policy to include:

DHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+: 47,824
Findings	
	○ The circumstances under which the MCO may extend the timeframe to resolve a grievance or appeal; ○ The circumstances for ending the continuation of benefits while the appeal or State Fair Hearing is pending; and ○ The details for effectuation of reversed appeal resolutions. - Update the provider notification process and related documents to ensure each provider receives the most recent copy of the *Ombudsman Brochure* and *Member Grievance and Appeals Guide* as required.
Appendix V: Information Systems Capabilities Assessments	DHP is accredited by NCQA and as such is deemed by DHS as exempt from the ISCA review.

GHC-EC	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 54,945 SSI: 10,113
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Follow-Up After Hospitalization for Mental Illness* • *PIP-Like Postpartum Care*	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - The study questions, indicators, and study populations were clearly defined. - Knowledgeable, qualified teams were selected to conduct the projects. - Effective improvement strategies were developed and implemented. - Analysis and interpretation of the data was based on a continuous quality improvement philosophy. Progress - The MCO addressed recommendations from CY 2019 related to the study topic, study population, and study indicators; all of these standards were met for both projects in CY 2020. - Overall, the MCO met 84.8 percent of applicable standards in CY 2020, compared to 75.7 percent of applicable standards in CY 2019. Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. - One project needs to define data sources and data collection tools for all measures, and include information on staff responsible, along with their qualifications, to conduct medical record abstraction. - For one project, the MCO should ensure data is collected for each intervention to determine its effectiveness, and continue to explore reasons for less than optimal performance.
Protocol 2: Validation of Performance Measures	Strengths - Timeliness of Prenatal Care. - Controlling Blood Pressure. - Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. - Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment.

GHC-EC	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 54,945 SSI: 10,113
Findings	
	Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Facilitate Combo 3-Childhood Immunization. - Improve Postpartum Care. - Follow-Up after Hospitalization for Mental Illness. - Follow-Up after Emergency Department Visit for Mental Illness.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	Not applicable. GHC-EC's last compliance review was conducted in October, 2019
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review* *Sample Size: 100*	Strengths - The MCO continued to have processes in place to complete the screening within the required timelines and prior to development of the care plan for its enrollees. - Behavioral health needs were identified and follow-up occurred to ensure needs were met. - Member care plans were reviewed and updated as required. - The MCO had processes in place to restratify members after a critical event. Progress - Member needs were addressed by ensuring care plans were developed with the member, evidence-based, and documented in the member record. - Highest need members were supported through enhanced documentation of WICT processes and functions. Recommendations - Complete and document comprehensive screenings that include the members' perception of their strengths and general well-being.
Appendix V: Information Systems Capabilities Assessments	Not applicable. GHC-EC's last ISCA was conducted in October, 2019

GHC-SCW	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+: 7,756
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Lead Screening* • *PIP-Like Postpartum Care*	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - The study questions, indicators, and study populations were clearly defined. - Knowledgeable, qualified teams were selected to conduct the projects.

GHC-SCW	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+: 7,756
Findings	
	- Analysis identified limitations of the project. Progress - The project focused on lead screening was continued from CY 2019, and demonstrated quantitative improvement in CY 2020. - The MCO addressed recommendations from CY 2019 to document a data analysis plan, utilized continuous cycles of improvement to measure and analyze improvement, ensured interventions were culturally and linguistically appropriate, and explored reasons for less than optimal improvement. - The MCO met all applicable standards for both projects in CY 2020, as compared to 80.6 percent of applicable standards in CY 2019. Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. - One project should obtain repeat measures to demonstrate the sustainability that has been achieved.
Protocol 2: Validation of Performance Measures	Strengths - Timeliness of Prenatal Care. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Facilitate Combo3-Childhood Immunization. - 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 has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement.
	
	Progress
	- This is the first year of the review and therefore there is no progress to report.
	
	Recommendations
	- Amend documentation to provide assurances that out-of-network requests for second opinions are available at no cost to the member.
	- Update the *Prior Authorizations/Referrals for Out-of-Network Providers for Services* policy and procedure to include the following:
	  ○ As identified by the DHS-HMO Contract, the length of time services will be provided to a member by an out-of-network provider; and
	  ○ That the cost to the member for using an out-of-network provider would be no greater than it would be if the services were furnished within the network.

GHC-SCW	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+: 7,756
Findings	
	- Develop a mechanism to demonstrate that the provider network includes sufficient family planning providers to ensure timely access to covered services. - Ensure the process for monitoring provider network adequacy includes the anticipated BC+ enrollment. - Develop and implement a policy and procedure to direct staff on processing system based disenrollments, and involuntary disenrollments due to just cause or a change in member circumstance. In addition, ensure the newly developed policy and procedure includes exemption requests from MCO enrollment that align with the DHS-MCO contract requirements. - Amend the *Pre-Service, Concurrent & Post Services Reviews and Timely Determinations* policy and procedure to include the ability of a member or provider to request an extension to the standard and expedited decision-making timeframes. - Revise the *Out-Of-Area Care* policy and procedure to incorporate the following requirements: o Post-stabilization of care related to coverage and payment, specifying the medical professional responsible for determining when the member is sufficiently stabilized for transfer or discharge; and o Remove the limitation for coverage for urgent and/or emergency services to members who are temporarily more than 50 miles from a GHC-SWC clinic or the nearest contracted clinic/facility, and ensure the policy does not refuse to cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO. - Revise the *Peer Review Committee* charter to address the requirement of immediately providing notification to the Department of any providers terminated from the network as a result of quality issues. - Amend the *Clinical Practice Guidelines Development* policy and procedure to address the DHS-MCO contract requirement to disseminate practice guidelines to members upon request. - Incorporate the requirement to have a mechanism to detect both under and overutilization of services into the quality improvement program. - Develop a policy and procedure to address the issuance of notices of adverse benefit determination when previously authorized services are reduced, terminated, or suspended. - Amend the *Pre-Service, Concurrent & Post Services Reviews and Timely Determinations* policy and procedure to include the following: o The issuance of written notifications of adverse benefit determination when claims are denied and when the MCO is unable to make a decision on a service authorization request in a timely manner; and o The ability of members and providers to request an extension to the standard authorization decision-making timeframe. - Ensure the MCO informs members of the right to file a grievance if he or she disagrees with a decision to extend the standard service authorization timeframe. - Revise the *Appeal/Grievance Process – Member Appeals Committee* policy and procedure to identify or incorporate the following:

GHC-SCW	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+: 7,756
Findings	
	○ If the MCO fails to adhere to the notice and timing requirements for resolving appeals, then the member is determined to have exhausted the GHC-SCW's appeal process and the member may initiate a State Fair Hearing; ○ Provide assurances that the format of the grievance resolution notification letter meets the standards described in the DHS *HMO and PIHP Communication, Outreach, and Marketing Guide*; ○ The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner if possible; ○ Specify that punitive action will not be taken against anyone who requests an expedited resolution of an appeal or supports a member's appeal; and ○ The processes related to continuation of benefits and recovery of the cost of services continued during the appeals process. - Clearly state in the *Appeal/Grievance Process – Member Appeals Committee* policy and procedure that the MCO does not deny requests for expedited appeals, and processes all requests for expedited appeals according to the expedited appeal timeframe.
Appendix V: Information Systems Capabilities Assessments	GHC-SCW is accredited by NCQA and as such is deemed by DHS as exempt from the ISCA review.

*i*Care	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 30,577 SSI: 10,572
Findings	
Protocol 1: Validation of Performance Improvement Projects • *PIP-Like Postpartum Care* • *Reduce Readmission Rate*	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - Knowledgeable, qualified teams were selected to conduct each project. Progress - The percentage of applicable standards met declined from 94.6 percent in CY 2019, to 54.5 percent in CY 2020. Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. - One project should specify the staff responsible for all data collection, and clearly specify a data analysis plan. - The other project should clearly state the goal of the study question; define measurable indicators, the study population, data to be collected, and data sources; describe how interventions were selected; address cultural or linguistic appropriateness of the member-facing interventions; and clearly present numerical results that answer the study question relevant to the defined study population.
Protocol 2: Validation of Performance Measures	Strengths

*i*Care	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 30,577 SSI: 10,572
Findings	
	- Follow-Up after Emergency Department Visit for Mental Illness. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Improve Combo3-Childhood Immunization. - Facilitate Immunizations for Adolescents. - Improve Postpartum Care. - Timeliness of Prenatal Care. - Controlling Blood Pressure. - Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	Strengths - The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. - The organization demonstrated the ability to ensure coordination and continuity of member care. - The organization has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement. Progress - The MCO developed and implemented a policy and written guidance related to restrictive measures. - The online provider directory was updated to include the non-English languages spoken by ancillary providers. - The MCO updated policies and procedures to demonstrate how the MCO comprehensively assesses the adequacy of the provider network. - Policies and procedures related to the use of out-of-network providers have been updated to reflect these providers are covered for as long as necessary when an in-network provider is not available. - Quality initiatives related to improving provider and subcontractor quality of care provided to members were integrated into the quality program and work plan. - The MCO updated the appeals resolution letter to include information regarding continuation of benefits and the potential liability for the cost of those benefits if the State Fair Hearing decision upholds the MCO's action. Recommendations - Revise the provider onboarding process to include the *Member Rights and Responsibilities* policy in the documents given to all new providers. - Update the *Advance Directives* policy to include the DHS-MCO contract requirements regarding staff training and community education. - Update the Care Management Quality Improvement Committee membership to include those specializing in mental health, substance abuse, or dental care on a consultant basis as required.

*i*Care	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 30,577 SSI: 10,572
Findings	

	- Update guidance to include all required timeframes for issuing written notices of adverse benefit determinations to members.
	- Revise guidance and other related materials to include the member's right to file a grievance if he or she disagrees with an extension to the timeframe for a standard service authorization decision.
	- Provide the *HMO and PIHP Grievances and Appeals Guide* to providers as required.
	- Update written guidance for the MCO's appeal process to include that the MCO must pay for services provided during an appeal if the MCO appeal process or State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services during the appeal.
	- Update the organization's *Member and DHS Notice of Provider Termination and Suspension* policy to ensure member notice is provided within 15 days of when a provider's contract is terminated.
	- Develop and implement a process to ensure practice guidelines adopted by the MCO are consistently identified across all documents.
	- Revise the *Medicaid Appeal Process* policy to include the following requirements:
	  ○ Attempts to resolve issues or concerns without formal hearings whenever possible;
	  ○ Clear guidance to staff for standard appeal extension requirements;
	  ○ Identification that members must request a State Fair Hearing no later than 90 calendar days from the date of the MCO's notice of resolution; and
	  ○ Provision of relevant materials to appropriate parties for a State Fair Hearing within five business days of the request for information.
	- Update the *Medicaid Grievance Process* policy to include the ability of a provider to file a grievance on behalf of a member.

Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review* *Sample Size: 100*	Strengths - The MCO had processes in place to complete the screening prior to development of the care plan for its enrollees - Member care plans were reviewed and updated as required - The MCO had processes in place to restratify members after a critical event. Progress - No progress demonstrated from the prior review. Recommendations - Complete and document comprehensive screenings that include the members' perception of both their strengths and general well-being. - Complete and document evidence-based care plans, including identifying interventions at the time of care plan development that are sequenced and meet member needs. - Provide timely post-hospitalization follow-up with members - Provide evidence of a well-functioning WICT.

*i*Care	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 30,577 SSI: 10,572
Findings	
Appendix V: Information Systems Capabilities Assessments	Not applicable. *i*Care's last ISCA was conducted in November, 2019.

MCHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+:15,950
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Lead Screening* • *PIP-Like Postpartum Care*	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - The study questions, indicators, and study populations were clearly defined. - Knowledgeable, qualified teams were selected to conduct each project. Progress - The MCO addressed recommendations from CY 2019 related to the study question, study indicators, and study population; the MCO met all scoring elements related to these standards in CY 2020. - The MCO met 76.5 percent of applicable standards in CY 2020, as compared to 44.4 percent of applicable standards in CY 2019. Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. - Both projects should specify the prospective data analysis plan. - One project should describe how interventions were selected, address cultural or linguistic appropriateness of interventions, document continuous improvement efforts in the report, and measure the effectiveness of the interventions.
Protocol 2: Validation of Performance Measures	Strengths - Timeliness of Prenatal Care. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Facilitate Combo 3-Childhood Immunization. - Improve Postpartum Care.

MCHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+:15,950
Findings	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	Strengths - The organization demonstrated the ability to ensure coordination and continuity of member care. - The organization has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement. - The organization has the structure and processes in place to provide a local system for grievances and appeals that also allows access to both DHS' grievances and appeals process, and the State Fair Hearing process. Progress - This is the first year of the review and therefore there is no progress to report. Recommendations - Revise the *Referral* policy to include: o The length of time services will be provided to a member by an out-of-network provider; o Details regarding the use of single-case agreements for out-of-network providers; and o Identification that the cost to the member for using an out-of-network provider would be no greater than it would be if the services were furnished within the network according to the DHS-HMO Contract. - Update the process for determining network adequacy to include considering the anticipated enrollment. - Develop and implement a member rights policy and procedure. - Update the credentialing process and related documents to include: o Assurance that providers serving high-risk populations or specializing in conditions with higher costs will not be discriminated against; and o Immediate notification to DHS when a provider is terminated for quality concerns. - Update the provider notification process and related documents to ensure each provider receives the most recent copy of the *Ombudsman Brochure* as required.
Appendix V: Information Systems Capabilities Assessments	MCHP is accredited by NCQA and as such is deemed by DHS as exempt from the ISCA review.

MHS	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 54,789 SSI: 6,739
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Comprehensive Diabetes Care*	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - The study questions, indicators, and study populations were clearly defined. - Appropriate sampling methods were utilized for both projects.

MHS	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 54,789 SSI: 6,739
Findings	
• *PIP-Like Postpartum Care*	- Knowledgeable, qualified teams were selected to conduct each project. - Effective improvement strategies were developed and implemented. - Analysis and interpretation of the data was based on a continuous quality improvement philosophy. Progress - The project focused on diabetes care was continued from CY 2019; however, the project did not demonstrate quantitative improvement in either year of the two-year project. - The MCO addressed recommendations from CY 2019 related to ensuring numerical results and findings were presented accurately and clearly, and the analysis of study data included an interpretation of the extent to which the PIP was successful. - The PIP-like postpartum care project met all applicable standards in CY 2020. - The MCO met 97.1 percent of applicable standards in CY 2020, compared to 81.6 percent of applicable standards in CY 2019. Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. - Continue to explore reasons for less than optimal performance for one project.
Protocol 2: Validation of Performance Measures	Strengths - Lead Screening in Children. - Follow-Up after Hospitalization for Mental Illness. - Follow-Up after Emergency Department Visit for Mental Illness. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Improve Combo 3-Childhood Immunization. - Facilitate Immunizations for Adolescents. - Improve Postpartum Care. - Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment.
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 coordination and continuity of member care. - The organization has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement. Progress - This is the first year of the review and therefore there is no progress to report.

MHS	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 54,789 SSI: 6,739
Findings	

	Recommendations
	- Update the *Single Case Agreements* policy and procedure to specify that the cost to the member for using an out-of-network provider would be no greater than it would be if the services were furnished within the network according to the DHS-HMO Contract.
	- Develop and implement a process to take corrective action against a network provider if there is a failure to comply with State standards for timely access to care and services.
	- Ensure the process for monitoring provider network adequacy includes the anticipated BC+ and SSI enrollment, and a verification process to ensure network providers provide physical access, reasonable accommodations, and accessible equipment to Medicaid members with physical or mental disabilities.
	- Amend the *Timeliness of UM Decisions and Notifications* policy and procedure to include the ability of a member or provider to request an extension to the standard and expedited decision-making timeframes.
	- Revise the *Emergency Services* policy and procedure to clearly state that the attending emergency physician or the provider actually treating the member is the medical professional responsible for determining when the member is sufficiently stabilized for transfer or discharge.
	- Develop and implement a restraint policy and procedure.
	- Revise the *Practitioner Disciplinary Action and Reporting* policy and procedure to address the requirement of immediately providing notification to the Department of any providers terminated from the network as a result of quality issues.
	- Incorporate a mechanism to detect under and overutilization of services into the quality program and quality work plan.
	- Amend the *Appeal of UM Decisions* policy and procedure to include the following information:
	  ○ Grievance and appeal system requirements specific to the state of Wisconsin, including the requirement that the MCO may only have one level of appeal for members;
	  ○ The ability of members to request an extension to the appeal resolution timeframe;
	  ○ The provision of oral notification to the member of the extension to the appeal resolution timeframe;
	  ○ The timeframe for issuance of written notification to the member when the appeal resolution timeframe is extended;
	  ○ The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner if possible; and
	  ○ The timeframe by which the MCO provides information about the grievance and appeal system to all providers and subcontractors, including the *Ombudsman Brochure*.
	- Develop and implement a process related to the issuance of written notification of adverse benefit determinations when claims are denied.
	- Revise the *Timeliness of UM Decisions and Notifications* policy and procedure to address the following DHS-MCO contract requirements:

MHS	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 54,789 SSI: 6,739
Findings	
	○ Notifying members of the right to file a grievance if they disagree with an extension to the standard service authorization decision timeframe; ○ The timeframe for issuing a written notice of denial to a member is a request is denied; and ○ The length of time allowed for an extension to the expedited service authorization decision timeframe if the member requests the extension. - Include an evaluation of under and overutilization of services in the annual *Medicaid QI Program Evaluation.* - Clearly state in the *Appeal of UM Decisions* policy and procedure that the MCO does not deny requests for expedited appeals, and processes all requests for expedited appeals according to the expedited appeal timeframe.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review* *Sample Size: 100*	Strengths - The MCO had processes in place to ensure members were restratified following a critical event. - The MCO completed all required WICT member face-to-face contacts. Progress - Member needs were addressed by ensuring care plans were developed with the member, and documented in the member record. Recommendations - Although the MCO demonstrated improvement, the organization should continue to update the care plan and associated processes to ensure the care plans are shared with the member and PCP and documentation reflects evidence-based care plans. - Ensure that care plans are member-centric including member engagement, evidence of readiness to change, and asking if needs are met according to the member. - Address social determinants of health needs with members. - Address behavioral health needs with members. - Complete and document annual care plan review and updates with members. - Provide timely post-hospitalization follow-up with members. - Provide evidence of a well-functioning WICT. - Ensure claims reporting correctly reflects WICT member services provided to members.
Appendix V: Information Systems Capabilities Assessments	MHS is accredited by NCQA and as such is deemed by DHS as exempt from the ISCA review.

MHWI	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 69,041 SSI: 3,471
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Follow-Up After Emergency Department Visit for Mental Illness* • *PIP-Like Postpartum Care*	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - The study questions, indicators, and study populations were clearly defined. - A knowledgeable, qualified team was selected to conduct one project. - Effective improvement strategies were developed and implemented. - Analysis and interpretation of the data was based on a continuous quality improvement philosophy. Progress - The MCO addressed recommendations from CY 2019 related to the study indicators, study population, and clearly defined the data to be collected along with the source of data. - The PIP-like postpartum care project met all applicable standards in CY 2020. - The MCO met 97.1 percent of applicable standards in CY 2020, compared to 81.6 percent of applicable standards in CY 2019. - Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. - One project should analyze data to discover reasons for less than optimal performance, and include information on staff responsible, along with their qualifications, to conduct medical record abstraction. - One project should continue to sustain the level of improvement achieved, and ensure all calculations are accurate throughout the report.
Protocol 2: Validation of Performance Measures	Strengths - Lead Screening in Children. - Timeliness of Prenatal Care. - Follow-Up after Hospitalization for Mental Illness. - Follow-Up after Emergency Department Visit for Mental Illness. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Facilitate Combo 3-Childhood Immunization. - Improve Postpartum Care. - Controlling Blood Pressure. - Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment.
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.

MHWI	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 69,041 SSI: 3,471
Findings	
	- The organization demonstrated the ability to ensure coordination and continuity of member care. - The organization has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement. - The organization has the structure and processes in place to provide a local system for grievances and appeals that also allows access to both DHS' grievances and appeals process, and the State Fair Hearing process. Progress - This is the first year of the review and therefore there is no progress to report. Recommendations - Update the *Adverse Action Reporting to the National Practitioner Data Bank (NPDB) and applicable State Agencies* document or related state-specific addendum to include immediate notification to DHS when a provider is terminated for quality concerns. - Update the provider notification process and related documents to ensure each provider receives the most recent copy of the *Ombudsman Brochure* and *Member Grievance and Appeals Guide* as required.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review* *Sample Size: 100*	Strengths - The MCO had processes in place to ensure members were restratified after critical events. Progress - Face-to-face member contacts are conducted and documented as required for the MCO's highest needs members. Recommendations - Ensure the member's agreement with the care plan is clearly documented prior to implementation. - Develop a care plan process to include sharing the member's care plan with the member and their primary care physician. - Follow-up with the member after a hospitalization and ensure the follow-up is timely. - Conduct WICT team meetings that include core team collaboration. - Complete and document comprehensive screenings that include the members' perception of their strengths and general well-being.
Appendix V: Information Systems Capabilities Assessments	MHWI is accredited by NCQA and as such is deemed by DHS as exempt from the ISCA review.

MCW	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 22,961 SSI: 3,421
Findings	
Protocol 1: Validation of Performance Improvement Projects	Strengths

MCW	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 22,961 SSI: 3,421
Findings	
• *Care Management Practices (Legacy CW)* • *Care Transitions (Legacy CW)* • *PIP-Like Postpartum Care (Legacy Trilogy)* • *Well-Child Visits (Legacy Trilogy)*	- The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - The study questions, indicators, and study populations were clearly defined. - Knowledgeable, qualified teams were selected to conduct the projects. - Continuous cycles of improvement were utilized to analyze and determine the effectiveness of interventions as the projects progressed. - Effective improvement strategies were developed and implemented. Progress - The MCO addressed recommendations from CY 2019 related to the study indicators, study population, data collection procedures, improvement strategies, and data analysis. - The PIP-like postpartum care project and the well-child visits project met all applicable standards in CY 2020. - The MCO met 91.4 percent of applicable standards in CY 2020, compared to 75.0 percent of applicable standards in CY 2019. Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. - For two projects, the MCO should ensure inclusion and exclusion of members in each project adhere to the defined study population, all indicators should be clearly defined as the studies are modified, and ensure initial and repeat measures are comparable. - For one project, the MCO should continue to sustain the level of improvement that has been achieved. - Another project should ensure the timeframes for the baseline and remeasurement periods align.
Protocol 2: Validation of Performance Measures	Strengths - Controlling Blood Pressure. - Follow-Up after Hospitalization for Mental Illness. - Follow-Up after Emergency Department Visit for Mental Illness. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Improve Combo 3-Childhood Immunization. - Facilitate Immunizations for Adolescents. - Improve Postpartum Care. - Timeliness of Prenatal Care.

MCW	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 22,961 SSI: 3,421
Findings	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Legacy CW*	Strengths - The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected. - The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. - The organization demonstrated the ability to ensure coordination and continuity of member care. Progress - The organization was newly formed in January 2020. The evaluation conducted in CY2021 is the first evaluation conducted for the MCO. Recommendations - Revise procedures to incorporate immediate notification of providers terminated due to quality of care concerns and parties excluded from participation in Federal health care programs to DHS and other entities as required. - Update the *Vendor Contracting* policy to align with the practices described during the interview session, to assure prospective subcontractors are able to perform the activities to be delegated prior to delegation. - Specify the use of consultants and describe the types of providers who participate in the various quality committees. - Incorporate a mechanism to analyze and address member input as part of the quality program. - Continue efforts to develop a mechanism to detect and address potential underutilization and overutilization of all services and to identify trends related to the adequacy of the provider network. - Develop a comprehensive written report of the overall effectiveness of the QAPI program, which incorporates data, findings, and analysis related to all of the quality initiatives identified in the *Quality Management Program Description 2020*. - Place priority on updating the *Complaints, Grievances and Appeals - SSI Managed Care* policy, as well as other documentation related to the organization's grievances and appeals processes, to include all requirements outlined in DHS's *HMO and PIHP Member Grievances and Appeals Guide 3.0.* - Revise the processes in place to ensure all required information regarding the MCO's grievance and appeals system is given to providers and subcontractors at the time of contracting and within three weeks of receiving updated information from DHS.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Legacy Trilogy*	Strengths - The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected. - The organization ensures the 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.

MCW	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 22,961 SSI: 3,421
Findings	
	- The organization has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement. - The organization has the structure and processes in place to provide a local system for grievances and appeals that also allows access to both DHS' grievances and appeals process, and the State Fair Hearing process. Progress - The organization was newly formed in January 2020. The evaluation conducted in CY2021 is the first evaluation conducted for the MCO. Recommendations - Develop and implement methods to provide the required community education about issues concerning advanced directives. - Develop and implement a procedure for reporting providers excluded for quality concerns to DHS and any other required entities. - Update the QAPI program description to incorporate monitoring the data about provider preventable conditions, and ensure the ongoing monitoring and reporting occurs as required by the DHS-MCO contract.
Protocol 9: Conducting Focused Studies of Health Care Quality *Legacy CW* *SSI Care Management Review* *Sample Size: 100*	Strengths - No strengths identified for the MCO. Progress - No progress demonstrated from the prior review. Recommendations - Complete and document comprehensive screenings that include members' perception of their strengths and general well-being. - Complete and document evidence based care plans, including prioritization of goals. - Address social determinants of health needs with members. - Ensure that care plans are member-centric including member engagement, evidence of readiness to change, and asking if needs are met according to the member. - Provide timely post-hospitalization follow-up with members. - Provide evidence of a well-functioning WICT.
Appendix V: Information Systems Capabilities Assessments *Legacy CW and Legacy Trilogy*	Not Applicable. The MCO was formed in 2020 and has not been reviewed.

NHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 56,163 SSI: 4,615
Findings	
Protocol 1: Validation of Performance Improvement Projects	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services.

NHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 56,163 SSI: 4,615
Findings	
• *Comprehensive Diabetes Care* • *PIP-Like Postpartum Care*	- The study questions, indicators, and study populations were clearly defined. - Knowledgeable, qualified teams were selected to conduct each project. - Effective improvement strategies were developed and implemented. - Analysis and interpretation of the data was based on a continuous quality improvement philosophy. Progress - The project focused on diabetes care was continued from CY 2019; however, the project did not demonstrate quantitative improvement in either year of the two-year project. - The MCO addressed recommendations from CY 2019 related to ensuring numerical results and findings were presented accurately and clearly, and the analysis of study data included an interpretation of the extent to which the PIP was successful. - The PIP-like postpartum care project met all applicable standards in CY 2020. - The MCO met 97.0 percent of applicable standards in CY 2020, compared to 79.5 percent of applicable standards in CY 2019. Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. Continue to explore reasons for less than optimal performance for one project.
Protocol 2: Validation of Performance Measures	Strengths - Lead Screening in Children. - Timeliness of Prenatal Care. - Controlling Blood Pressure. - Follow-Up after Emergency Department Visit for Mental Illness. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Facilitate Combo 3-Childhood Immunization. - Improve Immunizations for Adolescents. - Improve Postpartum Care. - Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. - Follow-Up after Hospitalization for Mental Illness. - Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment.

NHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 56,163 SSI: 4,615
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 coordination and continuity of member care.
	- The organization has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement.
	
	Progress
	- This is the first year of the review and therefore there is no progress to report.
	
	Recommendations
	- Update the *Single Case Agreements* policy and procedure to specify that the cost to the member for using an out-of-network provider would be no greater than it would be if the services were furnished within the network in alignment with expectations in the DHS-HMO Contract.
	- Develop and implement a process to take corrective action against a network provider if there is a failure to comply with State standards for timely access to care and services.
	- Ensure the process for monitoring provider network adequacy includes the anticipated BC+ and SSI enrollment, and a verification process to ensure network providers provide physical access, reasonable accommodations, and accessible equipment to Medicaid members with physical or mental disabilities.
	- Amend the *Timeliness of UM Decisions and Notifications* policy and procedure to include the ability of a member or provider to request an extension to the standard and expedited decision-making timeframes.
	- Revise the *Emergency Services* policy and procedure to clearly state that the attending emergency physician or the provider actually treating the member is the medical professional responsible for determining when the member is sufficiently stabilized for transfer or discharge.
	- Develop and implement a restraint policy and procedure.
	- Revise the *Practitioner Disciplinary Action and Reporting* policy and procedure to address the requirement of immediately providing notification to the Department of any providers terminated from the network as a result of quality issues.
	- Incorporate a mechanism to detect under and overutilization of services into the quality program and quality work plan.
	- Amend the *Appeal of UM Decisions* policy and procedure to include the following information:
	  ○ Grievance and appeal system requirements specific to the state of Wisconsin, including the requirement that the MCO may only have one level of appeal for members;
	  ○ The ability of members to request an extension to the appeal resolution timeframe;
	  ○ The provision of oral notification to the member of the extension to the appeal resolution timeframe;
	  ○ The timeframe for issuance of written notification to the member when the appeal resolution timeframe is extended;

NHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 56,163 SSI: 4,615
Findings	
	○ The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner if possible; and ○ The timeframe by which the MCO provides information about the grievance and appeal system to all providers and subcontractors, including the *Ombudsman Brochure*. - Develop and implement a process related to the issuance of written notification of adverse benefit determinations when claims are denied. - Revise the *Timeliness of UM Decisions and Notifications* policy and procedure to address the following DHS-MCO contract requirements: ○ Notifying members of the right to file a grievance if they disagree with an extension to the standard service authorization decision timeframe; ○ The timeframe for issuing a written notice of denial to a member is a request is denied; and ○ The length of time allowed for an extension to the expedited service authorization decision timeframe if the member requests the extension. - Include an evaluation of under and overutilization of services in the annual *Medicaid QI Program Evaluation.* - Clearly state in the *Appeal of UM Decisions* policy and procedure that the MCO does not deny requests for expedited appeals, and processes all requests for expedited appeals according to the expedited appeal timeframe.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review* *Sample Size: 100*	Strengths - No strengths identified for the MCO. Progress - Member care plans were reviewed and updated as required. Recommendations - Complete and document comprehensive screenings that include members' perception of their strengths and general well-being. - Although the MCO demonstrated improvement, it should continue updating the care plan and associated processes to ensure the care plans are shared with the member and PCP, and documentation reflects evidence-based care plans. - Ensure that care plans are member-centric including member engagement, evidence of readiness to change, and asking if needs are met according to the member. - Provide member-centric care that includes outreach attempts as identified in the MCO policy. - Address behavioral health and social determinants of health needs with members. - Provide timely post-hospitalization follow-up with members. - Provide evidence of a well-functioning WICT. - Ensure claims reporting correctly reflects WICT member services provided to the member.

NHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 56,163 SSI: 4,615
Findings	
Appendix V: Information Systems Capabilities Assessments	NHP is accredited by NCQA and as such is deemed by DHS as exempt from the ISCA review.

Quartz	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+: 51,815
Findings	
Protocol 1: Validation of Performance Improvement Projects • *PIP-Like Postpartum Care* • *Well-Child Visits*	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - The study questions, indicators, and study populations were clearly defined. - Knowledgeable, qualified teams were selected to conduct each project. - Effective improvement strategies were developed and implemented. Progress - The MCO addressed recommendations from CY 2019 related to data collection procedures, conducted analysis according to the data analysis plan, included initial and repeat measures, and identified project or study limitations. - The MCO met 87.9 percent of applicable standards in CY 2020, compared to 86.8 percent of applicable standards in CY 2019. Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. - One project should conduct continuous cycles of improvement if interventions are not effective. - The other project should describe how interventions were selected, and ensure initial and repeat measures are comparable.
Protocol 2: Validation of Performance Measures	Strengths - Timeliness of Prenatal Care. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Facilitate Combo 3-Childhood Immunization. - Improve Postpartum Care.

Quartz	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+: 51,815
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 ensures the availability of accessible, culturally competent services through a network of qualified service providers.
	- The organization demonstrated the ability to ensure coordination and continuity of member care.
	- The organization has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement.
	- The organization has the structure and processes in place to provide a local system for grievances and appeals that also allows access to both DHS' grievances and appeals process, and the State Fair Hearing process.
	
	Progress
	- This is the first year of the review and therefore there is no progress to report.
	
	Recommendations
	- Update the *Out of Network Care and Services* policy and related documents to include that the MCO will provide a second opinion at no cost to the member.
	- Ensure the process for monitoring provider network adequacy includes the anticipated BC+ enrollment.
	- Update the *Provider Manual* and other related documents to incorporate the following DHS-MCO contract requirements:
	  ○ Assure that a member who has an emergency medical condition may not be held liable for payment for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member; and
	  ○ Specify the medical professional responsible for determining when the member is sufficiently stabilized for transfer or discharge related to post-stabilization of care needs.
	- Revise the *Credentialing Policies* and related documents to include assurance that providers serving high-risk populations or specializing in conditions with higher costs will not be discriminated against.
	- Update the provider notification process and related documents to ensure each provider receives the most recent copy of the *Ombudsman Brochure* and *Member Grievance and Appeals Guide* as required.
	- Revise the *BadgerCare Plus Appeal and Grievance* policy to include:
	  ○ The circumstances for ending the continuation of benefits while the appeal or State Fair Hearing is pending; and
	  ○ The details for effectuation of reversed appeal resolutions.

Appendix V: Information Systems Capabilities Assessments	Quartz is accredited by NCQA and as such is deemed by DHS as exempt from the ISCA review.

SHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+: 73,195
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Lead Screening* • *PIP-Like Postpartum Care*	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - The study questions, indicators, and study populations were clearly defined. - Knowledgeable, qualified teams were selected to conduct each project. Progress - The percentage of applicable standards met declined from 81.1 percent in CY 2019 to 66.7 percent in CY 2020. Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. - Both projects should identify a prospective data analysis plan, document continuous improvement efforts, and describe how new interventions were selected. - Ensure the accuracy of the final numerator for one project.
Protocol 2: Validation of Performance Measures	Strengths - Timeliness of Prenatal Care. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - 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 has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement. Progress - This is the first year of the review and therefore there is no progress to report. Recommendations - Update the *Non-Affiliated Provider: Referrals/Emergencies/Non-emergent/Non-urgent* policy and procedure to incorporate the following DHS-MCO contract requirements: o Specify the length of time services will be provided to a member by an out-of-network provider; o Assure that a member who has an emergency medical condition may not be held liable for payment for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member; and

SHP	
Programs Operated	**CY 2021 Enrollment by Program**
BC+	BC+: 73,195
Findings	
	○ Specify the medical professional responsible for determining when the member is sufficiently stabilized for transfer or discharge related to post-stabilization of care needs. - Ensure the process for monitoring provider network adequacy includes the anticipated BC+ enrollment, and the expected utilization of services considering member characteristics and health care needs. - Amend the *BadgerCare Primary Care Provider (PCP)* policy and procedure to identify the process for informing members of their assigned primary care provider and how to contact the provider. - Develop and implement a policy and procedure to direct staff on processing involuntary disenrollments due to just cause or a change in member circumstance. - Revise the *UM-Timeliness of Decisions* policy and procedure to include the ability of a member to request an extension to the expedited decision-making timeframe. - Amend the *Preventive Health and Clinical Practices Guideline* policy and procedure to address the DHS-MCO contract requirement to disseminate practice guidelines to members upon request. - Incorporate the requirement to have a mechanism to detect both under and overutilization of services into the quality improvement program. - Develop a policy and procedure to address the issuance of notices of adverse benefit determination when previously authorized services are reduced, terminated, or suspended. - Revise the *BadgerCare and SSI Appeals* policy and procedure to address the following DHS-MCO contract requirements: ○ Ensure the appeal resolution letter includes a statement that the member may be held liable for the cost of continuing benefits during the State Fair Hearing process; and ○ Detail the information documented within the *OnBase Appeal* software module for each member appeal. - Incorporate a mechanism to address the DHS-MCO contract requirement to distribute the *Ombudsman Brochure* to providers at the time a contract is entered.
Appendix V: Information Systems Capabilities Assessments	SHP is accredited by NCQA and as such is deemed by DHS as exempt from the ISCA review.

UHC	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 222,816 SSI: 19,993
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Follow-Up After Hospitalization for Mental Illness*	Strengths - The project topics focused on improving a key aspect of care for members, and were selected through a comprehensive analysis of member needs, care, and services. - The study questions, indicators, and study populations were clearly defined. - Knowledgeable, qualified teams were selected to conduct each project. - Effective improvement strategies were developed and implemented.

UHC	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 222,816 SSI: 19,993
Findings	
• *PIP-Like Postpartum Care*	- Analysis and interpretation of the data was based on a continuous quality improvement philosophy. Progress - The MCO addressed recommendations from CY 2019 and ensured interventions were culturally and linguistically appropriate, conducted analysis according to the data analysis plan, included initial and repeat measures, and identified project or study limitations. - The project focused on follow-up after hospitalization for mental illness was continued in CY 2020, and met all applicable standards. This project also demonstrated quantitative improvement in CY 2020. - The MCO met 97.1 percent of applicable standards in CY 2020, compared to 79.5 percent of applicable standards in CY 2019. Recommendations - Continue to work with DHS on the transition of the PIP-like project to a PIP project for MY 2021. - Both projects should ensure all calculations are accurate throughout the reports. - One project should include information on staff responsible, along with their qualifications, to conduct medical record abstraction. - The other project should continue to sustain the level of improvement achieved.
Protocol 2: Validation of Performance Measures	Strengths - Lead Screening in Children - Combo 3-Childhood Immunization. - Timeliness of Prenatal Care. - Controlling Blood Pressure. - Follow-Up after Hospitalization for Mental Illness. Progress - Due to newly identified measures from the previous period progress could not be measured. Recommendations - Ensure Immunizations for Adolescents. - Improve Postpartum Care. - Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment.
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.

UHC	
Programs Operated	**CY 2021 Enrollment by Program**
BC+, SSI	BC+: 222,816 SSI: 19,993
Findings	
	- The organization has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement. - The organization has the structure and processes in place to provide a local system for grievances and appeals that also allows access to both DHS' grievances and appeals process, and the State Fair Hearing process. Progress - This is the first year of the review and therefore there is no progress to report. Recommendations - Update the provider notification process and related documents to ensure each provider receives the most recent copy of the *Ombudsman Brochure* and *Member Grievance and Appeals Guide* as required.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review* *Sample Size: 100*	Strengths - The MCO consistently completed restratification after identified critical events. Progress - Member needs were addressed by ensuring care plans were evidence-based. Recommendations - Complete and document comprehensive screenings that include the members' perception of their strengths and general well-being. - Increase documented outreach attempts to ensure efforts align with the MCO's identified contact requirements for each stratification level. - Ensure hard to reach members are stratified per contract expectations by updating MCO policies and practices. - Conduct and document timely post-hospitalization follow-up that includes all required activities. - Complete weekly core team meetings.
Appendix V: Information Systems Capabilities Assessments	UHC is accredited by NCQA and as such is deemed by DHS as exempt from the ISCA review.

CCF	
Programs Operated	**CY 2021 Enrollment by Program**
Children Come First	83
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Care Management Practices*	Strengths - The project topic focused on improving a key aspect of care for members, and was selected through a comprehensive analysis of member needs, care, and services. - The study question and study population were clearly defined. - A knowledgeable, qualified team was selected to conduct the project. - Effective improvement strategies were developed and implemented. - Analysis and interpretation of the data was based on a continuous quality improvement philosophy.

CCF	
Programs Operated	**CY 2021 Enrollment by Program**
Children Come First	83
Findings	
	Progress - The PIHP addressed recommendations to ensure the study question was stated as a clear, simple, answerable question with a numerical goal and target date. - The percentage of applicable standards met declined from 95.0 percent in CY 2019 to 88.9 percent in CY 2020. Recommendations - Identify an objective mechanism to establish the baseline, monitor results during the project, and complete a repeat measurement.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	Strengths - The organization demonstrated the ability to ensure coordination and continuity of member care. Progress - The MCO enhanced the training provided to staff regarding restrictive measures. - The provider directory included non-English languages spoken by some providers, but this information was not consistently updated for all providers since the previous review in CY 2018. - The MCO analyzed the geographic location of providers and members to determine the adequacy of the network. - The service authorization policy and procedure was updated to include the process for submitting authorization requests, the decision-making timeframes, and the ability to request extensions. - The MCO revised the quality work plan to including findings from the quality program activities and incorporated providers and subcontractors into the work plan. Recommendations - Update the *Out-of-Network Provider* policy, *CCF Family Handbook,* and other documents to reflect the requirement regarding the coverage of non-network providers for as long as the PIHP is unable to provide the necessary and covered service. - Ensure the process for monitoring provider network adequacy includes the anticipated BC+ enrollment. - Update the *Provider Application* and other provider selection documents to include the assurance that providers who serve high-risk populations or specialize in conditions that require higher-cost treatments will not be discriminated against. - Amend or update the PIHP's contract with its subcontractor RISE to include the right of the PIHP to approve, suspend, or terminate any provider. - Update the timeframe for notification of terminated providers to DHS in the *Provider Termination* policy to align with the requirement for immediate notification. - Revise the *Family Handbook* and other related documentation to identify that family requests for a change in child and family team membership are considered a grievance and must be addressed as such.

CCF	
Programs Operated	**CY 2021 Enrollment by Program**
Children Come First	83
Findings	
	- Update the PIHPs documentation to inform members of the right to request paper copies of the *Family Handbook* and *Provider Directory* free of charge. Include the timeframe when copies will be provided. - Update the *Enrollment* policy and *Intake Checklist* documents to ensure members are provided the *Family Handbook* no more than 10 days after receiving notice of the member's enrollment. - Update the *Participant Rights* policy, *Provider Manual,* and other related documents to ensure members and providers are informed that the PIHP may not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is their patient. - Update the *Advance Directive* policy and other documents to include the documents will be updated to reflect any changes in State law as soon as possible, but not later than 90 days from the effective date of change. - Place priority on developing and implementing a process for creation of an annual written evaluation of the organization's Quality Assessment and Performance Improvement (QAPI) work plan. - Update the PIHP's QAPI program to include input and approval from the PIHP's governing body of the CCF QAPI work plan, and document the senior executive responsible for the program's overall operation and success. - Update the *Grievances & Appeals* policy and procedure, as well as other documentation related to the organization's grievances and appeals processes, to include all requirements outlined in DHS's *HMO and PIHP Member Grievances and Appeals Guide 3.0.* - Update the *Service Authorization* policy and staff guidance to ensure notices of adverse benefit determination are issued as required. - Develop and implement a formal process to ensure practice guidelines are routinely reviewed and updated. - Update the provider network processes and practices to confirm each provider submits details regarding physical access (including reasonable accommodations) and ability to communicate with members who have limited English proficiency. Update the *Provider Directory* process to ensure these elements are clearly documented for each provider. - Continue efforts to assure all elements and aspects of the quality improvement program are thoroughly documented.
Appendix V: Information Systems Capabilities Assessments	Strengths - The organization demonstrated an all-encompassing internal system, *Human Services Web Application,* that is maintained and updated by a stable and experienced information system department. - A robust ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes. - The security systems meet or exceed most industry standards, ensuring consistent system and data availability. - The processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter data is provided to the state. Progress

CCF	
Programs Operated	**CY 2021 Enrollment by Program**
Children Come First	83
Findings	
	- The MCO remedied the challenges and improved the process related to ensuring the accuracy of claims data and encounter files. - The MCO successfully developed and implemented a disaster recovery plan. - The MCO automated the provider directory updates. Recommendations - Implement enhancements to the *Human Services Web Application* to eliminate the work-around process to enter back-dated claims; and add more diagnoses codes to its claims and encounter reporting information. - Update the new member onboarding processes to include steps that will uncover duplicates and aliases prior to entering the member into the *Human Services Web Application* and include defined Medicaid continuous enrollment with source code to ensure full compliance with continuous enrollment requirements. - Implement a process to routinely conduct Federal Information Processing Standards (FIPS) 140-2 tests to ensure full compliance and the integrity of the data.

WM	
Programs Operated	**CY 2021 Enrollment by Program**
Wraparound Milwaukee	947
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Care Management Practices*	Strengths - The project topic focused on improving a key aspect of care for members, and was selected through a comprehensive analysis of member needs, care, and services. - The study question and study population were clearly defined. - A knowledgeable, qualified team was selected to conduct the project. Progress - The percentage of applicable standards met declined from 84.2 percent in CY 2019 to 63.2 percent in CY 2020. Recommendations - Describe the planned and actual frequency of data analysis. - Ensure the data throughout the report is consistent and accurate. - Identify an objective mechanism to establish the baseline, monitor results during the project, and complete a repeat measurement.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards 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. - The organization has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement.

WM	
Programs Operated	**CY 2021 Enrollment by Program**
Wraparound Milwaukee	947
Findings	
	- The organization has the structure and processes in place to provide a local system for grievances and appeals that also allows access to both DHS' grievances and appeals process, and the State Fair Hearing process. - The organization's inclusion of a policy and procedure attestation in its contracting process ensures providers are aware of the requirements and their responsibilities related to timeliness, access, and quality of care including member rights. The attestation outlines specific policies for providers to be aware of and those that must be implemented by the provider. - The organization's home-grown electronic recordkeeping system, *Synthesis*, provides an all-encompassing, interconnected system that links every aspect of the organization's functions for WM staff and providers. Examples of the system's capabilities and strengths include: o Linking *Synthesis* with the online provider directory allowing real-time updates for care coordinators and members; o Providing one system for all member-related documentation; o Allowing for continuous monitoring of provider performance and provider network adequacy; o Enabling the organization to generate reports and queries from information retained in *Synthesis* to make data-driven decisions for the quality assurance/quality improvement program; and o Tracking, monitoring and documenting all grievances and appeals. - Including the PIHP's training modules online allows for in-time training to WM staff and contracted providers as needed. - WM staff reported a one-month disenrollment grace period, which allows for member-centric transition planning to other service types or natural support systems. Progress - The PIHP developed a mechanism to determine the geographic location of providers and members, considering the distance, travel time, and means of transportation ordinarily used by members, to assess the adequacy of the provider network. - The PIHP developed and implemented a method to monitor providers to ensure compliance with timely access to care and services. - Policies and procedures were updated to reflect decision-making timeframes for standard and expedited service requests, along with the ability to request extensions if more time is needed. - An appeal and grievance committee is in place at the organization. - The PIHP has a process in place to notify and allow members to request an extension to the timeframe for the disposition of a grievance or appeal. Recommendations - Develop and implement a second opinion policy and procedure, to align with processes described during the interview session, and to assure members have the ability to obtain a second opinion either within or outside the provider network at no cost to the member. - Continue outreach efforts to secure additional family representation on the quality committee to meet DHS-PIHP contract requirements.

WM	
Programs Operated	**CY 2021 Enrollment by Program**
Wraparound Milwaukee	947
Findings	
	- Develop a comprehensive written report of the overall effectiveness of the quality program, which incorporates data, findings, and analysis related to all of the quality initiatives identified in the quality work plan.
Appendix V: Information Systems Capabilities Assessments	Strengths - WM continues to use its home-grown electronic system, *Synthesis*, to manage enrollment, authorizations, provider network, claims, and encounter data. *Synthesis* centralizes all functions and allows for nearly real-time information availability. - *Synthesis is an* all-encompassing internal system that is maintained and updated by a stable and experienced information system department. - A thorough maintenance cycle is implemented to ensure the organization continues to meet the state Medicaid reporting requirements. - More than 99 percent of claims are submitted electronically, with no claims accepted by *Synthesis* until complete. Providers are notified automatically of any incorrect or missing information and continue to receive the notifications until the system identifies the claim as clean. - A vigorous ongoing training program to ensure Medicaid claims and encounter data are processed accurately and within the expected timeframes. - Security systems meets or exceeds most industry standards, ensuring nearly continuous system and data availability. - Processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter data is provided to the state Progress - Increased reporting options and opportunities within *Synthesis* for automation of all data validation and other system functions, including reports to monitor the timeliness of claims processing. - Formalized the processes for both provider submitted and internal data entry validation. Recommendations - Complete the conversion to FIPS compliant software, then routinely conduct FIPS 140-2 tests to ensure full compliance and the integrity of the data.

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.

UW - American Family Children's Hospital	
Programs Operated	**CY 2021 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
Care Management Review	Strengths - The organization had processes in place to ensure that all members met program eligibility.

UW - American Family Children's Hospital	
Programs Operated	**CY 2021 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
	- Assessments were comprehensive and completed timely to identify member needs. - Documentation indicated practices were in place to ensure timely care plans. - Care management practices and documentation ensured ongoing supportive contacts were met. - Member specific medical, social, and educational needs were addressed and documented in the record. - The organization had processes in place to coordinate and follow-up on referrals as needed for each member to ensure ongoing and quality care. Progress - Timely follow-up after hospitalizations. Recommendations - Complete comprehensive care plans that reflect the following: o Timeframes for actions/interventions; o Child-centric goals; and o Include goals that are specific, measurable, achievable, relevant, and timely (SMART).

Children's Hospital of Wisconsin	
Programs Operated	**CY 2021 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
Care Management Review	Strengths - The organization had processes in place to ensure that members met program eligibility requirements and voluntary consent was obtained. - Mutual agreement of termination was discussed with the family and documented in the record. - The organization had processes in place to follow-up within three days after hospitalization. - Member specific medical, social, and educational needs were addressed and documented in the record. - The organization had processes in place to coordinate and follow-up on referrals as needed for each member to ensure ongoing and quality care. Progress - Member needs were addressed by ensuring that medical, social, and educational needs were addressed and documented in the record. Recommendations - Comprehensive care plans that reflect the following: o Child-centric goals; o Measurable goals;

Children's Hospital of Wisconsin	
Programs Operated	**CY 2021 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
	○ Specific timeframes of when the action/intervention is to be completed/reviewed; and ○ Identification of who will complete the action/intervention to meet the goals

Marshfield Children's Hospital	
Programs Operated	**CY 2021 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
Care Management Review	Strengths - The hospital had processes in place to ensure that members met program eligibility requirements and voluntary consent was obtained when needed. - Medical, social, and educational needs were consistently assessed for each member and documented in the record. - Hospital processes and practices resulted in assessments and care plans consistently occurring within the required timeframes. - The CMC program staff maintained at least monthly contact with members and families to ensure all identified needs were met and services were provided in accordance with the care plan. - The organization's practices resulted in coordination and follow-up for referrals as needed for each member to ensure ongoing and quality care. Progress - CY 2021 was the first year the organization was reviewed; therefore, there is no data from a prior review to evaluate progress. Recommendations - Comprehensive care plans which reflect goals that: ○ Address all identified needs; ○ Are child-centric; and ○ Are SMART.

PROTOCOL 1[3]: VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

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

DHS contractually requires organizations operating BC+ and SSI programs to conduct two PIPs annually, which are based on DHS priority areas. While the MCOs may propose alternate topics, approval is at the discretion of DHS. For calendar year 2020 (CY 2020), the DHS-MCO contract specified that all BC+ MCOs were required to develop and implement a PIP focused on improving the MCO's postpartum care rates (as measured through the associated HEDIS measure), and on measuring and reducing health disparities in postpartum care among Wisconsin Medicaid members. Specific interventions were to be implemented at the MCO and provider/clinic levels. This required project was established as a PIP-like project because the design did not meet the CMS Protocol requirements; this project will set the foundation for addressing health disparities as a formal PIP project in CY 2021.

DHS contractually requires each organization participating in a prepaid inpatient health plan to conduct one or more PIPs annually, which are based on DHS priority areas. While the PIHP may propose alternate topics, approval is at the discretion of DHS.

The study methodology is assessed through the following steps:

- Review the selected study topic(s);
- Review the study question(s);
- Review the selected study indicators;
- Review the identified study population;
- Review sampling methods (if sampling used);
- Review the data collection procedures;
- Assess the MCO's improvement strategies;
- Review the data analysis and interpretation of study results;

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

- Assess the likelihood that reported improvement is *real* or true improvement, and not due to chance; and
- Assess the sustainability of the documented improvement.

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 CY 2020, organizations submitted proposals for non-health disparities projects to DHS and MetaStar by December 1, 2019, and proposals for health-disparities PIP-like projects by January 10, 2020. DHS directed MCOs to submit final reports by July 1, 2021.

Project Outcomes and Interventions

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

The quality initiatives of DHS cover a broad range of topics, and included the requirement for MCOs operating BC+ programs to conduct a Health Disparities Reduction PIP in CY 2020. The DHS initiative focused on reducing health disparities among Medicaid members, improving cultural competence of MCOs and providers serving Medicaid members, and compliance with the Managed Care Rule requirement defined in 42 CFR 438.340 (b). The validation result for the PIP-like projects is noted as *not applicable* in the table below due to the project design.

Performance Improvement Project Outcomes and Interventions CY 2020

*Note: The initial and repeat measures were not comparable. Therefore, if quantitative improvement was noted, it could not be confirmed.

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
Care Transitions					
MCW (SSI)	Improve the member record review results of the Discharge and Transition Care indicator.	22% (Fiscal Year 2019-2020)	54%* (2020)	Updated the existing *Care Transition Assessment* (CTA) tool. Provided education to staff regarding the completion of the CTA.	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
	Reduce the hospital readmission rate.	21.3% (2019)	18%* (2020)	Transferred assessment responsibilities from care coordinators to clinical staff. Conducted the CTA by telephone.	
Care Management Practices					
MCW (SSI)	Decrease the rate of difficult to contact (DTC) members.	14.9% (2019)	17.2%* (2020)	Modified the steps of the existing DTC outreach process. Implemented more timely and consistent outreach efforts during the first 60 days of enrollment. Changed the amount of time between ongoing attempts to contact DTC members.	Partially Met
Composite Measure Improvement					
Anthem (SSI)	Increase the total composite points associated with five HEDIS pay for performance measure initiatives.	5 total points (2018)	5 total points (2020)	Utilized the SSI case management team based approach to managing a member's case coordination. Simplified the *CareCompass* health risk assessment and case notes. Offered a Healthy Rewards incentive program to members. Deployed a field-based licensed clinical social worker and advocate.	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				Provided an appointment scheduling incentive. Implemented a Housing First program to provide housing to the MCO's highest need mentally ill members. Continued the embedded community health worker provider collaboration. Offered a *HealthCrowd* interactive voice recognition and text campaign to members to improve communication and care coordination. Implemented a safety net housing program to provide housing to pregnant members and those discharging from skilled nursing facilities.	
Comprehensive Diabetes Care (CDC)					
CCHP (BC+)	Improve the rate of completion of an annual dilated retinal exam (DRE).	51.58% (2017)	40.30% (2020)	Shared information on member's diagnosis of diabetes with Herslof Optical. Faxed results of member's DRE to their primary care physician. Offered incentives to	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				members for completion of the DRE. Provided member education through mailings. Completed TeleVox calls reminding members they were eligible to receive an incentive because they completed a DRE. Re-initiated the Facebook Campaign to vary the method of communication to members focusing on the importance of DREs.	
MHS (SSI)	Improve the hemoglobin A1c (HbA1c) in control rate of greater than 8.0%.	54.35% (2018)	46.72% (2020)	Included diabetic test results in the MCO's documentation system. Incorporated a diabetic assessment into all initial and ongoing member outreach calls. Referred members for ongoing diabetic education. Provided diabetic education to non-clinical staff. Conducted targeted outreach to members with a diabetic test result between 9.0 and 10.0 percent.	Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				Completed targeted outreach to members with a missing diabetic test result or those with an elevated test result of greater than 8.0 percent. Increased member awareness and usage of a web-based resource to assist members with self-managing their chronic diseases. Offered in-home diabetic testing kits to members.	
NHP (SSI)	Improve the HbA1c in control rate of greater than 8.0%.	56.83% (2018)	47.92% (2020)	Included diabetic test results in the MCO's documentation system. Incorporated a diabetic assessment into all initial and ongoing member outreach calls. Referred members for ongoing diabetic education. Provided diabetic education to non-clinical staff. Conducted targeted outreach to members with a diabetic test result between 9.0 and 10.0 percent. Completed targeted outreach to members with a	Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				missing diabetic test result or those with an elevated test result of greater than 8.0 percent. Increased member awareness and usage of a web-based resource to assist members with self-managing their chronic diseases. Offered in-home diabetic testing kits to members.	
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
MHWI (SSI)	Improve the HEDIS FUM rate.	66.22% (2019)	73.4% (2020)	Added value-based contracts with key provider groups that included the FUM measure in 2020. Trained care managers to identify and assist members who fall into the FUM measure with obtaining follow-up care. Expanded referrals for Team Connect visits for all members in Milwaukee county who had an emergency department visit for a mental health issue.	Met
30-day Follow-Up After Hospitalization for Mental Illness (FUH-30)					
GHC-EC (SSI)	Improve the HEDIS FUH-30 rate.	66.7% (2018)	55.9% (2020)	Improved the communication strategy to the Patient Care Coordinator. Partnered with	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				Vantage Point Clinic to provide telehealth visits/assessment after discharge.	
UHC (SSI)	Improve the HEDIS FUH-30 rate.	55.08% (2017)	68.39% (2020)	Implemented provider education through a contracted agency focusing on behavioral health resources and initiatives, and the FUH-30 measure. Promoted telehealth visits with providers and members. Continued the onsite care coordination program within two mental health systems, which included four mental health facilities.	Met
Lead Screening in Children (LSC)					
GHC-SCW (BC+)	Improve the HEDIS LSC rate.	68.18% (2018)	71.82% (2020)	Created a Lead Screening Committee to monitor the LSC rate and address barriers throughout the project. Conducted member outreach. Modified an existing incentive program. Emailed providers to encourage sharing incentive program information with members. Created a monthly LSC gap in care report for providers.	Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
MCHP (BC+)	Improve the HEDIS LSC rate.	64.91% (2018)	74.73% (2020)	Conducted member outreach via phone calls and mailings. Educated providers on the importance of lead screening in children. Provided report cards to providers with their lead screening results. Distributed a flyer that included a spotlight on lead poisoning to clinic providers and clinic staff. Coordinated with MercyHealth system lab partners to review lead screening options.	Partially Met
SHP (BC+)	Improve the HEDIS LSC rate.	77.66% (2018)	76.49% (2020)	Provided HealthCheck birthday and general reminder cards to providers to use as outreach to SHP members. Sent gaps in care lists to quality leadership staff at larger provider systems. Implemented a member incentive program to reward members who received a lead screening in MY 2020.	Partially Met
Reduce Readmission Rate					

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
*i*Care (SSI)	Reduce the mental health hospitalization readmission rate.	55% (2019)	Not Calculated (2020)	Completed transition of care assessments. Created and implemented a Behavioral Health Program Specialist position.	Not Met
Well-Child Visits (WCV)					
DHP (BC+)	Improve the HEDIS rate of WCV in the first 15 months of life (W15).	52.08% (2018)	44.99% (2020)	Conducted member outreach through educational information on the DHP website. Mailed reminders to parents of members to schedule a well-child visit at specific age intervals. Distributed information to pregnant members on the importance of well-child visits and the frequency at which they are recommended to be completed. Highlighted the importance of well-child visits in a quarterly *CheckUp* member newsletter.	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
MCW (BC+)	Improve the HEDIS rate of adolescent WCV.	35.04% (2018)	73.32% (2020)	Conducted telephonic outreach to members and case heads. Notified primary care providers (PCPs) of members who needed appointments and/or immunizations. Mailed a reminder postcard to members.	Met
Quartz (BC+)	Improve the HEDIS W15 rate.	49.20% (2018)	41.59%* (2020)	Conducted outreach by telephone, mail, and electronically through the organization's electronic medical record, *MyChart*. Offered a monthly drawing for a $25.00 gift certificate. Provided information about Thrive, an application that provided education and care reminders to members. Improved collaboration with network clinics.	Partially Met
Care Management Practices – Children Only					
CCF	Improve the rate of reporting that emotional needs are being met in a school setting.	58% (2019)	66%* (2020)	Provided training to care coordinators. Distributed educational materials to new and currently enrolled members. Invited school personnel to care planning meetings.	Partially Met

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
WM	Increase the care coordinator's sense of immediate engagement with their newly enrolled families through the warm hand off process more than that of the control group in both Phase 1 and Phase 2 of the project.	No baseline calculated (2019)	+2.13% of change over control group in Phase 1 (May 18, 2020 – September 4, 2020) -2.22% of change over control group in Phase 2 (September 7, 2020 – December 28, 2020)	Conducted training about the project for all screeners and care coordinators. Implemented a warm handoff phone call during phase one of the project. Conducted a warm handoff virtual meeting during phase two of the project.	Partially Met
	Increase the newly enrolled family's sense of immediate engagement with their care coordinator through the warm hand off process more than that of the control group in both Phase 1 and Phase 2 of the project.	No baseline calculated (2019)	-1.29% of change over control group in Phase 1 (May 18, 2020 – September 4, 2020) +5.31% of change over control group in Phase 2 (September 7, 2020 – December 28, 2020)		
	Reduce the disenrollment/dropout rate for families that experience the warm handoff as compared to the rate for those in the control group in both Phase 1 and Phase 2 of the project.	No baseline calculated (2019)	-71% of change over control group in Phase 1 (May 18, 2020 – September 4, 2020) -33% of change over control group in Phase 2 (September 7, 2020 –		

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
			December 28, 2020)		
Metabolic Monitoring – Children Only					
CCHP (FCMH)	Reduce the rate of children with only one of two antipsychotic medication measure tests being completed.	36% (2018)	28% (2019)	Increased education for prescribing providers and internal staff about the importance of metabolic monitoring tests. Identified laboratory tracking opportunities to increase care coordination follow-up and continued education provided to staff. Embedded laboratory draws at the time of the Initial Comprehensive Health Exam.	Met
Prenatal and Postpartum Care (PPC) – PIP-Like Project					
Anthem (BC+)	Improve the postpartum HEDIS PPC rate.	66.3% (2018)	Reported but not Validated: 72.2%* (2020)	Established a partnership with Columbia St. Mary's Family Health Center. Completed a cultural competence self-assessment and plan for the MCO and partner clinic. Selected doulas as the non-traditional culturally-competent maternity provider for the MCO and partner clinic. Offered online training related to health disparities, cultural competency,	Not Applicable

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				and prenatal/ postpartum quality for all in-network providers.	
CCHP (BC+)	Improve the postpartum HEDIS PPC rate.	79.08% (2019)	Reported but not Validated: 75.67% (2020)	Completed a cultural competence self-assessment. Developed a cultural competence work plan. Partnered with Ascension St. Joseph Campus, Women's Outpatient Center. Continued the Advanced Practice Nurse Prescriber home visiting program. Increased the number of post-delivery phone calls to members. Established networks for doula services with community agencies.	Not Applicable
DHP (BC+)	Improve the postpartum HEDIS PPC rate.	75.39% (2018)	Reported but not Validated: 78.83%* (2020)	Completed a cultural competence self-assessment and plan for the MCO and partner clinic. Selected doulas as the non-traditional culturally-competent maternity provider for the MCO. Established a partnership with Dean Health Group Fish Hatchery	Not Applicable

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				Clinic. Conducted provider training at the partner clinic and two other locations.	
GHC-EC (BC+)	Improve the postpartum HEDIS PPC rate.	66.7% (2018)	Reported but not Validated: 74.2%* (2020)	Completed a cultural competence self-assessment and plan for the MCO and its partner clinic, Prevea Health. Selected doula services and traditional healers as the non-traditional culturally competent maternity providers for the MCO. Compiled and distributed a list to pregnant members, by county, of non-traditional culturally-competent maternity providers in the MCO's network, including type of service they provide. Established a partnership with Prevea Health. Conducted provider training at the partner clinic. The partner clinic selected nurse mid-wives, doula services, and traditional healers as its non-traditional culturally competent maternity providers.	Not Applicable

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				Mailed outreach letters to pregnant members in their primary language informing them of the importance of prenatal and postpartum visits.	
GHC-SCW (BC+)	Improve the postpartum HEDIS PPC rate.	74.97% (2018)	Reported but not Validated: 83.3%* (2020)	Established a partnership with GHC-SCW Hatchery Hill clinic. Completed a cultural competence self-assessment and plan for the MCO and partner clinic. Selected doulas as the non-traditional culturally-competent maternity provider for the MCO and partner clinic. Offered the YWCA Racial Equity and Inclusion Foundational Learning Series training for all MCO and partner clinic staff.	Not Applicable
*i*Care (BC+)	Improve the postpartum HEDIS PPC rate.	61.83% (2018)	Reported but not Validated: 65.21%* (2020)	Completed a cultural competence self-assessment and plan for the MCO and partner clinic. Selected community health workers as the non-traditional culturally-competent maternity provider for the MCO. Partnered with the Advocate Aurora West Allis Women's	Not Applicable

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				Health Pavilion. Conducted member outreach by telephone.	
MCHP (BC+)	Improve the postpartum HEDIS PPC rate.	78.03% (2018)	Reported but not Validated: 82.54%* (2020)	Partnered with Mercy Clinic West for the delivery of culturally competent care to the underrepresented population. Conducted provider training at the partner clinic. Completed a cultural competence self-assessment and plan for the MCO and its partners. Participated in a learning collaborative. Selected doulas as the non-traditional culturally competent maternity provider.	Not Applicable
MCW (BC+)	Improve the postpartum HEDIS PPC rate.	65.5% (2018)	Reported but not Validated: 63.99%* (2020)	Established a partnership with ProCare Medical Group. Completed a cultural competence self-assessment and plan for the MCO and partner clinic. Offered video training to partner clinic staff.	Not Applicable
MHS (BC+)	Improve the postpartum HEDIS PPC rate.	55.3% (2018)	Reported but not Validated: 73.24%* (2020)	Completed a cultural competence self-assessment and plan for the MCO and partner clinic.	Not Applicable

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				Selected doulas and a maternal community health worker as the non-traditional culturally-competent maternity providers for the MCO. Established a partnership with Advocate Aurora Clinic. Conducted provider training at the partner clinic. Conducted year-round member chart reviews to obtain data for the PPC rate if a claim was not located. Surveyed members on postpartum appointment barriers. Conducted a virtual member focus group. Performed telephonic member outreach. Addressed food insecurity for underrepresented pregnant members through referrals to community-based organizations. Referred pregnant members to prenatal care coordination	

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				programs, as appropriate.	
MHWI (BC+)	Improve the postpartum HEDIS PPC rate.	71.3% (2019)	Reported but not Validated: 70.1% (2020)	Completed a cultural competence self-assessment and plan for the MCO and partner clinic. Selected community health workers as the non-traditional culturally-competent maternity provider for the MCO. Established a partnership with Progressive Community Health Center. The partner clinic selected community health workers as its non-traditional, culturally-competent provider type. Implemented a Community Connector intervention to members in hospitals in Milwaukee and Racine counties, to provide education on the importance of scheduling postpartum appointments, scheduled the appointments, and arranged transportation. Mailed a postpartum incentive postcard to all members.	Not Applicable

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				Made a Care Connections home visit by a nurse practitioner for members in Milwaukee, Racine, Waukesha, Washington, and Ozaukee counties who were not seen at the hospital or did not attend their scheduled appointment. Completed telephonic outreach to members that did not participate in the Community Connector intervention at the hospital or the Care Connections home visit, assisted in scheduling the postpartum care appointment, arranged transportation, and addressed other barriers.	
NHP (BC+)	Improve the postpartum HEDIS PPC rate.	64.82% (2018)	Reported but not Validated: 70.1%* (2020)	Completed a cultural competence self-assessment and plan for the MCO and partner clinic. Selected doulas and a maternal community health worker as the non-traditional culturally-competent maternity providers for the MCO. Established a partnership with	Not Applicable

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				Advocate Aurora Clinic. Conducted provider training at the partner clinic. Conducted year-round member chart reviews to obtain data for the PPC rate if a claim was not located. Surveyed members on postpartum appointment barriers. Conducted a virtual member focus group. Performed telephonic member outreach. Addressed food insecurity for underrepresented pregnant members through referrals to community-based organizations. Referred pregnant members to prenatal care coordination programs, as appropriate.	
Quartz (BC+)	Improve the postpartum HEDIS PPC rate.	85.16% (2019)	Reported but not Validated: 83.45% (2020)	Completed a cultural competence self-assessment and plan for the MCO and partner clinic. Selected community health workers as the non-traditional culturally-competent	Not Applicable

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
				maternity provider for the MCO and partner clinic. Established a partnership with UW Health Union Corners clinic. Conducted telephonic and electronic outreach to members. Provided information about the Community Partnership Program support group.	
SHP (BC+)	Improve the postpartum HEDIS PPC rate.	68.86% (2018)	Reported but not Validated: 79.08%* (2020)	Partnered with Marshfield Medical Center for the delivery of culturally competent care to the underrepresented population. Conducted provider training at the partner clinic. Completed a cultural competence self-assessment and plan for the managed care organization (MCO) and partner clinic. Selected doulas as the non-traditional culturally-competent maternity provider for the MCO. Participated in a learning collaborative.	Not Applicable

MCO	Indicator, Measure, or Aim	Outcomes		Interventions	Validation Result
		Baseline	Final Result		
UHC (BC+)	Improve the postpartum HEDIS PPC rate.	72.26% (2018)	Reported but not Validated: 78.10%* (2020)	Completed a cultural competence self-assessment and plan for the MCO and partner clinic. Selected doulas services, community health workers, and peer support as the non-traditional culturally-competent maternity providers for the MCO. Established a partnership with Froedtert OB/GYN. Conducted provider training at the partner clinic. The partner clinic selected Mothers and Maternal Support as its non-traditional, culturally-competent provider type. Implemented remote patient monitoring.	Not Applicable

*Note: The initial and repeat measures were not comparable. Therefore, if quantitative improvement was noted, it could not be confirmed.

Aggregate Results for Performance Improvement Projects

The following table lists each standard that was evaluated for each MCO and PIHP, and indicates the number of projects meeting each standard. Some standards were not applicable to all projects, due to the study design, results, or implementation stage. CY 2019 project results are provided for comparison.

Please note that the DHS-MCO contract incorporated requirements for programs providing the BC+ benefit to conduct a health disparities project focused on postpartum care in CY 2020. The health disparities postpartum projects were not standard PIP projects as they were not designed in accordance with the CMS Protocol. As a result, MetaStar did not validate the outcomes or

results of the PIP-like projects. Therefore, elements 18-22 were noted as not applicable for the PIP-like projects, and are reflected in the table below.

CY 2020 Performance Improvement Project Validation Results

Standards and Elements		CY 2020 (n=33)	CY 2019 (n=33)
Study Topic(s)			
1	The topic was selected through MCO data collection and analysis of important aspects of member needs, care, or services.	33/33 (100.0%)	30/33 (90.9%)
Study Question(s)			
2	The problem to be studied was stated as a clear, simple, answerable question(s) with a numerical goal and target date.	32/33 (97.0%)	31/33 (93.9%)
Study Indicator(s)			
3	The study used objective, clearly and unambiguously defined, measurable indicators and included defined numerators and denominators.	30/33 (90.9%)	29/33 (87.9%)
4	Indicators are adequate to answer the study question, and measure changes in any of the following: health or functional status, member satisfaction, processes of care with strong associations with improved outcomes.	32/33 (97.0%)	32/33 (97.0%)
Study Population			
5	The project/study clearly defined the relevant population (all members to whom the study question and indicators apply).	31/33 (93.9%)	29/33 (87.9%)
6	If the entire population was used, data collection approach captured all members to whom the study question applied.	17/18 (94.4%)	26/27 (96.3%)
Sampling Methods			
7	Valid sampling techniques were used.	16/16 (100.0%)	6/6 (100.0%)
8	The sample contained a sufficient number of members.	16/16 (100.0%)	5/6 (83.3%)
Data Collection Procedures			
9	The project/study clearly defined the data to be collected and the source of that data.	27/33 (81.8%)	28/33 (84.8%)
10	Staff are qualified and trained to collect data.	29/33 (87.9%)	30/33 (90.9%)
11	The instruments for data collection provided for consistent, accurate data collection over the time periods studied.	30/33 (90.9%)	32/33 (97.0%)
12	The study design prospectively specified a data analysis plan.	26/33 (78.8%)	27/33 (81.8%)
Improvement Strategies			
13	Interventions were selected based on analysis of the problem to be addressed and were sufficient to be expected to improve outcomes or processes.	28/33 (84.8%)	30/33 (90.9%)
14	A continuous cycle of improvement was utilized to measure and analyze performance, and to develop and implement system-wide improvements.	27/33 (81.8%)	28/33 (84.8%)
15	Interventions were culturally and linguistically appropriate.	15/19 (78.9%)	23/33 (69.7%)
Data Analysis and Interpretation of Study Results			

Standards and Elements		CY 2020 (n=33)	CY 2019 (n=33)
16	Analysis of the findings was performed according to the data analysis plan, and included initial and repeat measures, and identification of project/study limitations.	25/33 (75.8%)	19/33 (57.6%)
17	Numerical results and findings were presented accurately and clearly.	30/33 (90.9%)	27/33 (81.8%)
18	The analysis of study data included an interpretation of the extent to which the PIP was successful and defined follow-up activities as a result.	14/19 (73.7%)	22/33 (66.7%)
"Real" Improvement			
19	The same methodology as the baseline measurement was used, when measurement was repeated.	15/19 (78.9%)	25/33 (75.8%)
20	There was a documented, quantitative improvement in processes or outcomes of care.	6/19 (31.6%)	7/33 (21.1%)
21	The reported improvement appeared to be the result of the planned quality improvement intervention.	5/7 (71.4%)	6/14 (42.9%)
Sustained Improvement			
22	Sustained improvement was demonstrated through repeated measurements over comparable time periods.	0/0 (0.0%)	1/1 (100.0%)

ANALYSIS

Thirty-three PIPs were submitted and reviewed; MetaStar validated 19 projects. Fourteen health disparities projects focused on postpartum care were designed as PIP-like projects. MetaStar reviewed the health disparities projects, but did not validate the project outcomes (standards 18-22), as the projects were not designed in accordance with the CMS Protocol.

The scope of the DHS *2021 Medicaid Managed Care Quality Strategy* includes improving access, member choice, and health equity; promoting appropriate, efficient, and effective care; focusing on patient-centered care and superior clinical outcomes; and employing principles of evidence-based continuous quality improvement. The CY 2020 PIP projects focused on improving key aspects of care for members, including care transitions to reduce hospitalizations or prevent readmissions, comprehensive diabetes care, care management practices, follow-up after emergency department utilization or hospitalization for mental illness, lead screening in children, well-child visits, metabolic monitoring, and reducing health disparities related to postpartum care.

Prior to implementation, all organizations submitted PIP project proposals for feedback on the first 12 standards, which relate to the review areas of topic selection, study question, indicators, study population, sampling methods, and procedures. When the final projects were validated, 51.5 percent of the projects fully met these first 12 standards in CY 2020, as compared to 57.6 percent of projects in CY 2019. The percentage of projects meeting the requirements related to the *Study Topic*, *Study Question*, *Study Indicators*, and *Sampling* standards improved or remained the same from year-to-year. However, the percentage of projects meeting the

requirements for all four of the elements related to the *Data Collection* standard declined from CY 2019 to CY 2020.

Improvement was noted from CY 2019 to CY 2020 in 54.5 percent of the standards, and one standard continued to be met 100 percent of the time. All of the projects conducted in CY 2020 were selected through MCO data collection and analysis of important aspects of member needs, care, or services. The percent of projects that analyzed the findings according to the data analysis plan, included initial and repeat measures, and identified project/study limitations improved from the prior review.

Six MCOs continued projects from CY 2019, but only two projects demonstrated quantitative improvement. The improvement in these two projects was noted to be the result of the planned quality improvement interventions. However, none of the projects demonstrated improvement that was sustained with repeat measures.

Documented, quantitative improvement in processes or outcomes of care was only evident in 31.6 percent of the validated projects. One MCO did not calculate a repeat measurement rate for the project. While an MCO may have reported an improvement in the measured rate for the project, the validation process did not always confirm the MCO's conclusion. In four of the 19 projects validated, initial and repeat measures were not comparable or there was a difference in how the baseline and repeat measures were calculated.

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

The overall validation findings provide an indication of the reliability and validity of the projects' results. As noted earlier, 14 projects focused on health disparities. The PIP-like structure for these projects did not allow for outcomes or results to be linked to the interventions deployed; therefore, overall validity and reliability could not be determined. The validation finding for these projects was noted to be *not applicable,* and are not included in the table below. CY 2019 project results are provided for comparison.

CY 2020 Performance Improvement Project Overall Validity Results

Validation Finding	CY 2020 (n=19)	CY 2019 (n=33)
Met	7 (36.8%)	10 (30.3%)
Partially Met	11 (57.9%)	22 (66.7%)
Not Met	1 (5.3%)	1 (3.0%)

Almost 37 percent of the projects in CY 2020 received validation ratings of fully *met*, as compared to 30 percent of projects in 2019. Five of the seven projects with a validation rating of *met* in CY 2020 met all applicable standards. The remaining two projects with a validation rating of *met* did not demonstrate quantitative improvement in processes or outcomes of care, but otherwise met all applicable standards.

Eleven projects received a partially met validation rating in CY 2020. In four of these projects the MCOs failed to recognize that the initial and repeat measures were based on different methodologies, which was evaluated as a barrier to the validity of the projects.

One project received a validation rating of not met. The PIP did not clearly state the goal of the study question, or define measurable indicators in order to answer the study question. In addition, the MCO altered the study population during the course of the project. As the indicators were not defined to answer the study question, the MCO did not calculate a repeat measurement rate to compare the results of the project to the baseline measure. The MCO fully met only 33.3 percent of applicable standards for this project.

As noted earlier, six MCOs continued a project from CY 2019. The overall validity rating for three projects remained the same in both years; one project continued to receive a *met* rating, and two projects continued to receive a partially met rating. Three of the continuing projects had a validation rating change from partially met in CY 2019, to met in CY 2020, due to the organizations' efforts to address recommendations from CY 2019.

CONCLUSIONS

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

PROTOCOL 2: VALIDATION OF PERFORMANCE MEASURES

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

The MCO quality indicators for CY 2020, reported in CY 2021, are set forth in the annual *Wisconsin 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 measures.

Beginning with the CY 2020 *Quality Guide*, DHS eliminated its state-developed measures and transitioned its P4P measures to two BC+ and one SSI composites. The BC+ composites were made up of a women's health composite (two HEDIS measures) and a children's health composite (three HEDIS measures). The SSI composite included five HEDIS 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 national 67th percentile;
- Two points for a rate at or above the national 50th percentile; and
- Zero points for a rate below the national 50th percentile.

Points could be earned for each measure below the national 50th percentile if the rate is at or above the MY 2018 state average. Based on the total points earned, each MCO could earn back a percentage of its annual withhold amount.

Each MCO's measure results are validated by a NCQA-certified HEDIS auditor, then submitted to DHS. MetaStar did not validate the CY 2020 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
Women's Health Composite			
Timeliness of Prenatal Care (PPC)	85.9%	76.4%	79.6%
Postpartum Care (PPC)	74.7%	85.9%	89.3%
Children's Health Composite			
Childhood Immunization Combo 3 (CIS)	66.3%	67.9%	72.8%
Immunizations for Adolescents Combo 2 (IMA)	38.8%	36.7%	43.6%
Lead Screening in Children (LSC)	76.9%	71.5%	77.9%

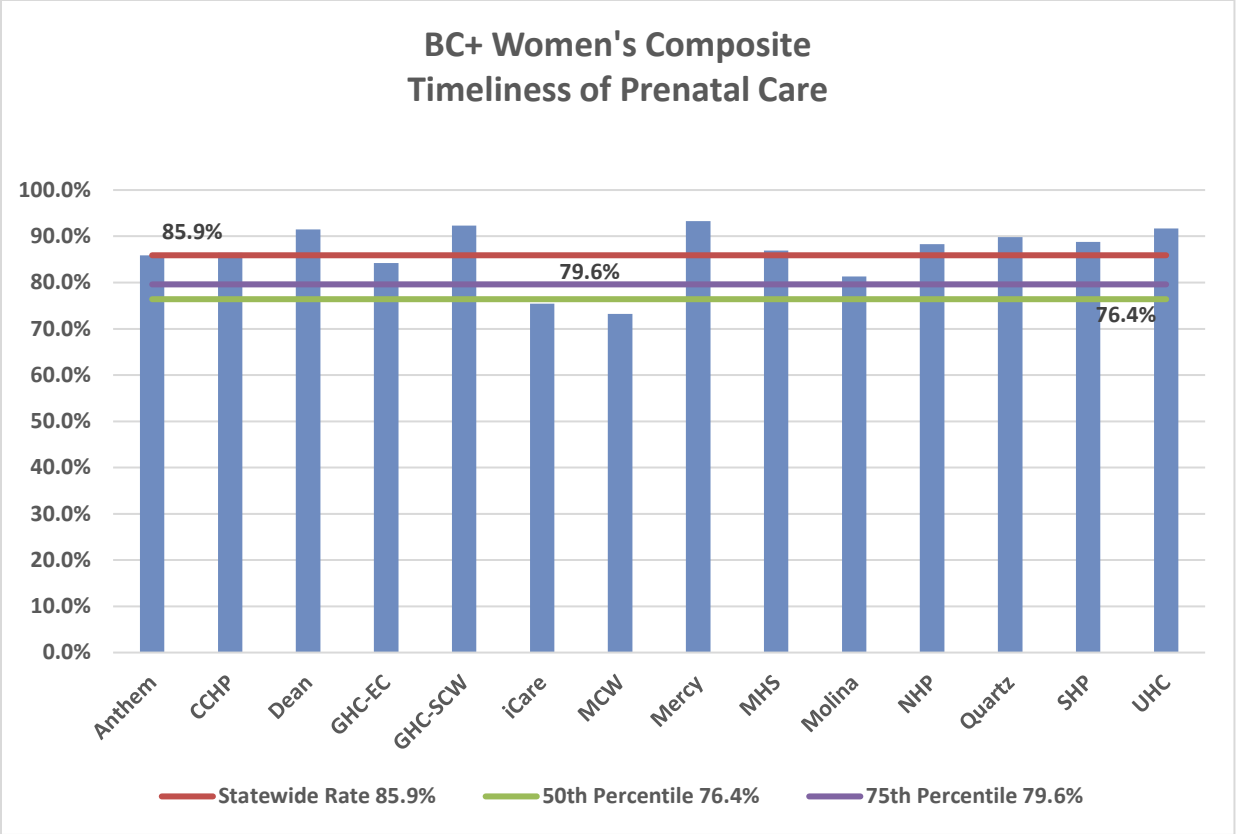
Program: SSI Composite Measures	Statewide Rate	50th Percentile	75th Percentile
Performance Measures			
Controlling Blood Pressure (CBP)	61.6%	55.4%	62.5%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	11.2%	14.0%	17.8%
Follow-Up after Emergency Department Visit for Mental Illness (FUM-30)	58.7%	53.5%	64.6%
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-30)	21.7%	21.3%	26.2%
Follow-Up after Hospitalization for Mental Illness (FUH-30)	61.7%	60.1%	67.5%

During CY 2020, HEDIS retired the W15, W34 and AWC measures. The three measures were combined into a new measure, Child and Adolescent Well-Care Visits. DHS removed the measures from the MY 2020 P4P composite in August, 2020.

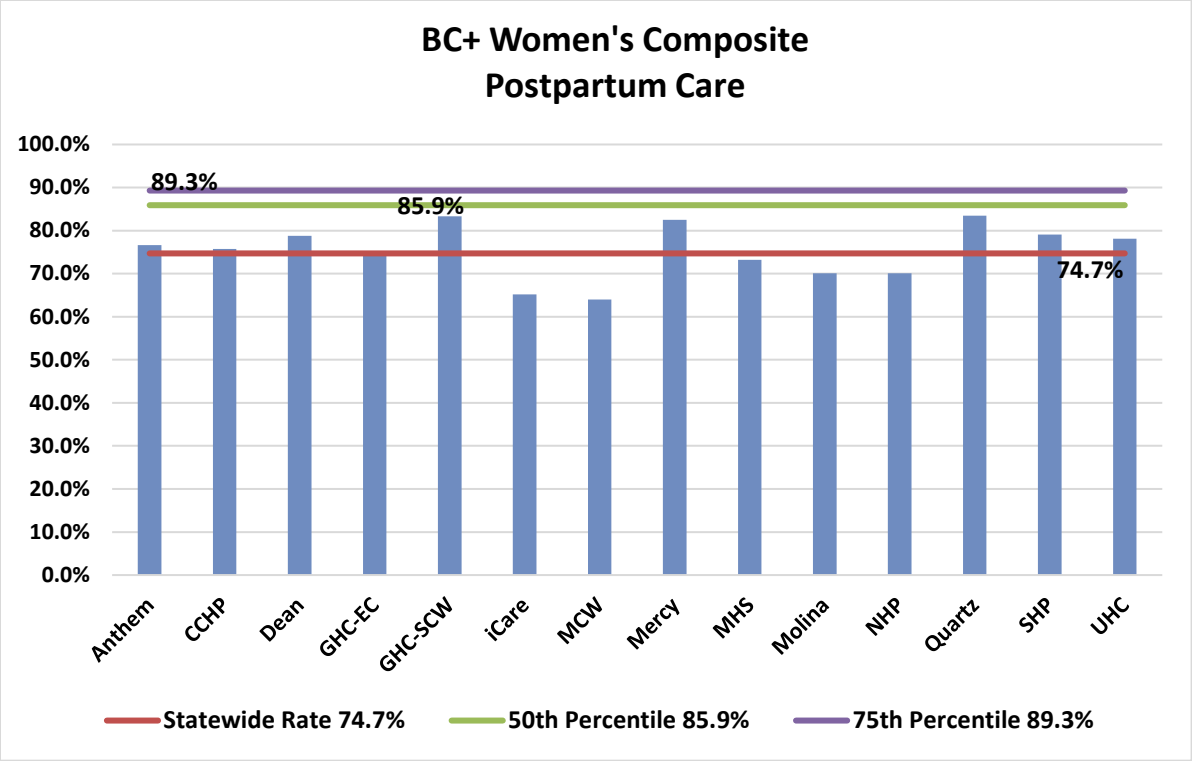
The results for each measure reported by MCO compared to the statewide aggregate and national benchmarks of the 50th percentile and 75th percentile are summarized below.

Women's Health Composite

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

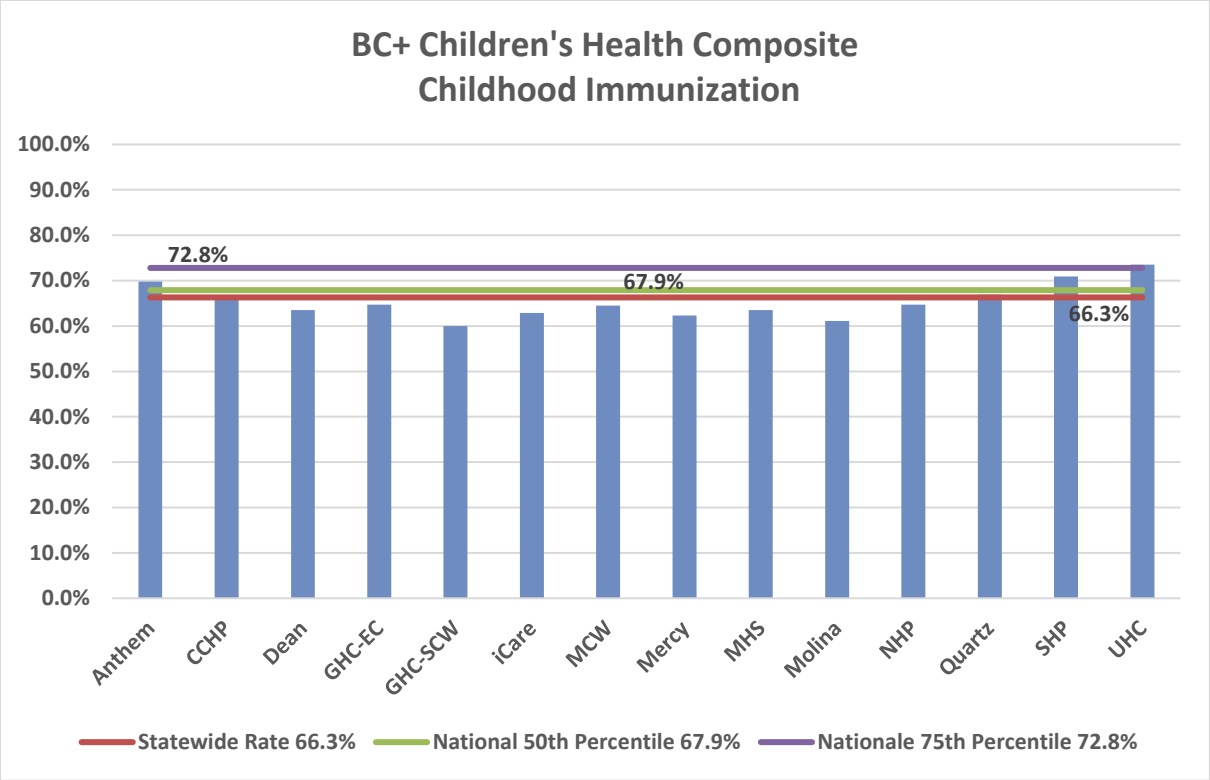


The following graph displays the results for the Postpartum Care measure by MCO.

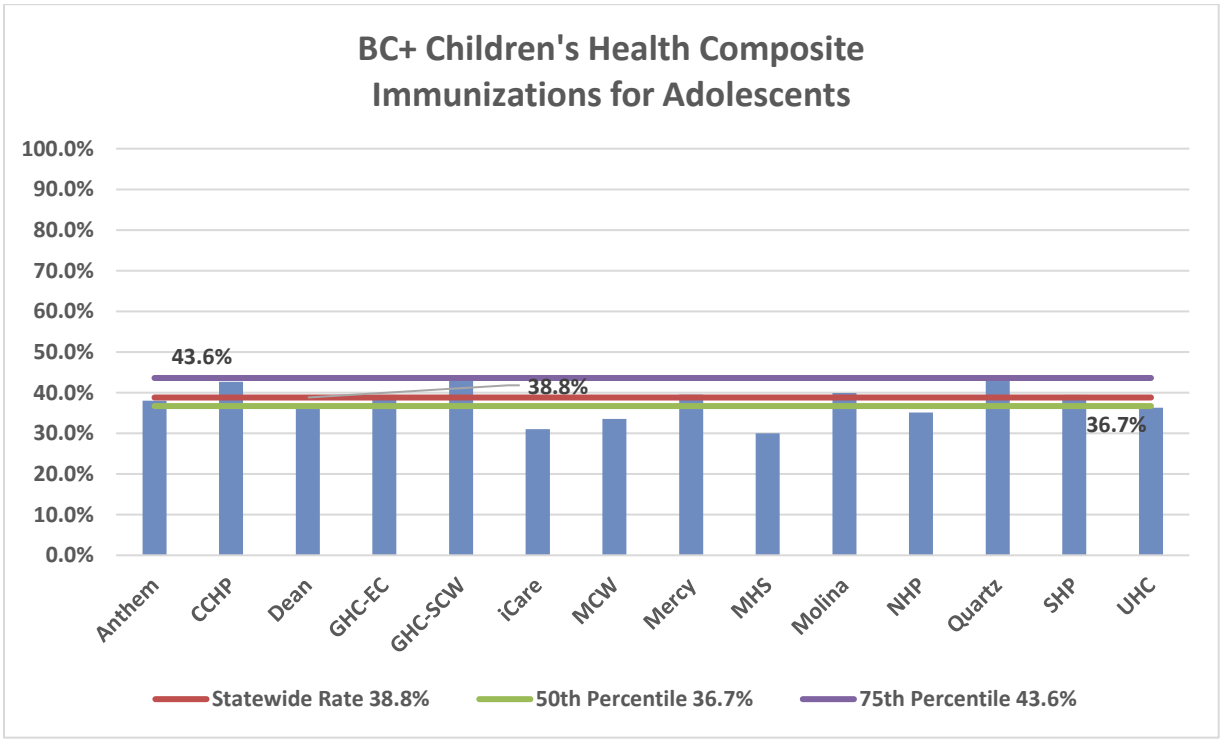


Children's Health Composite

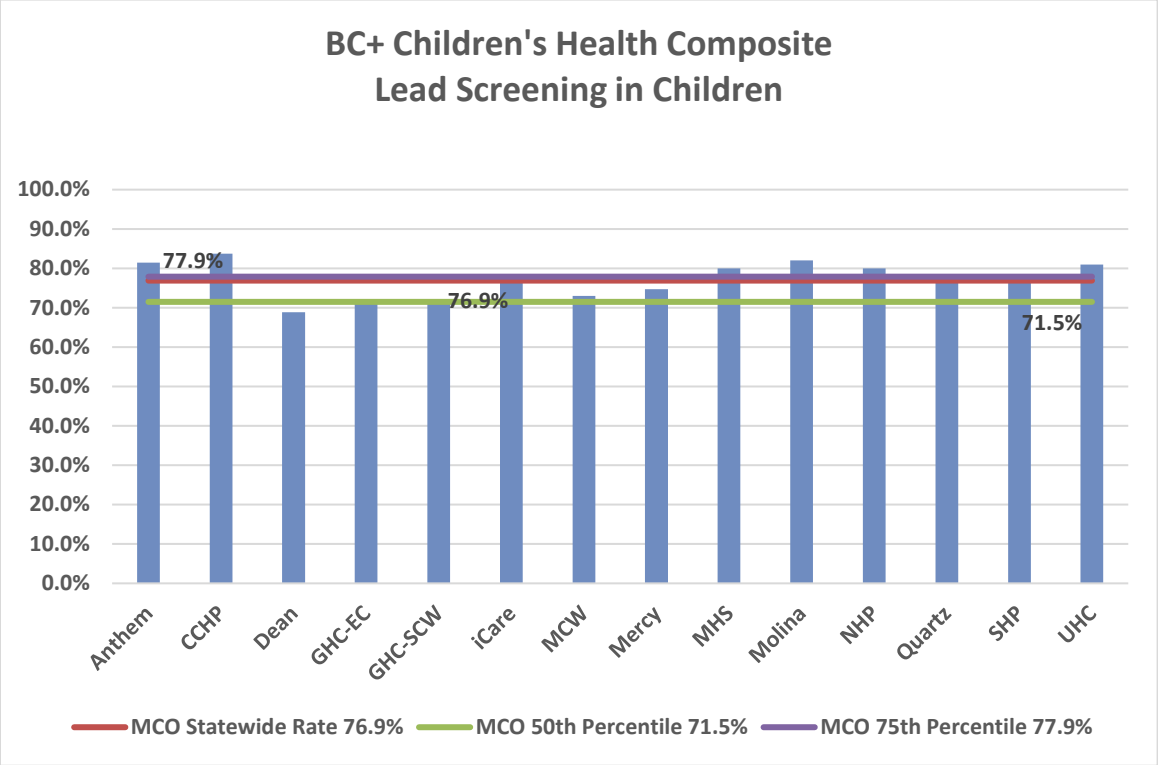
The following graph displays the results for Childhood Immunization Combo 3 by MCO.



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

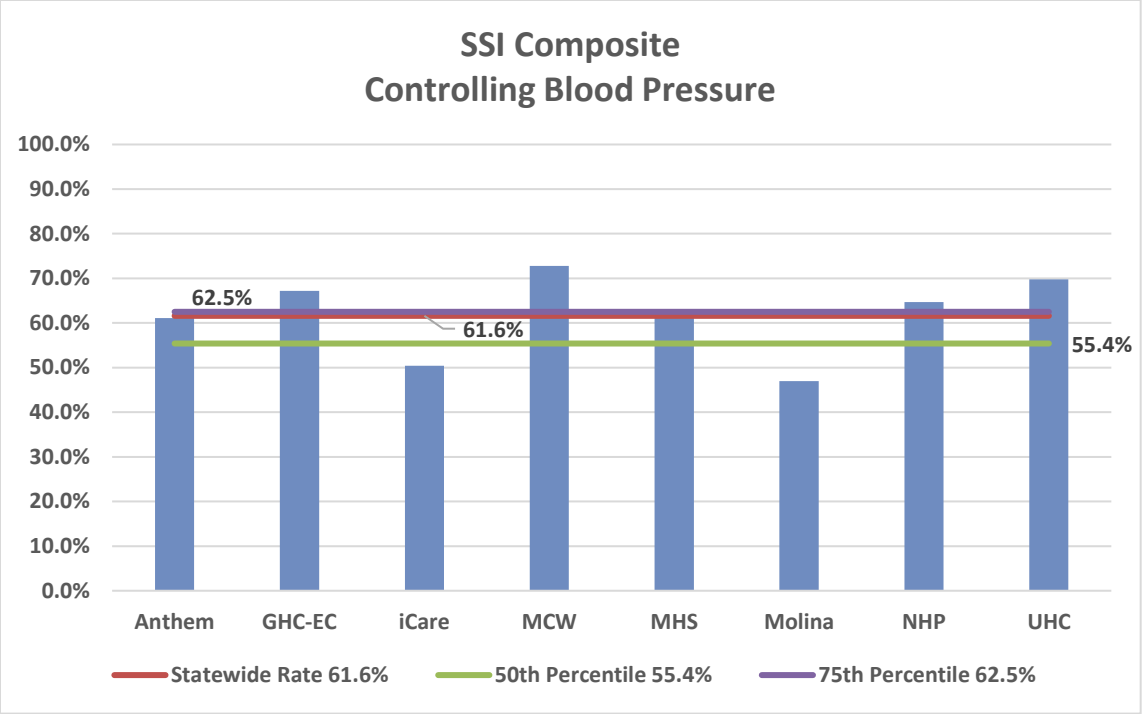


The graph below displays the results for Lead Screening in Children by MCO.

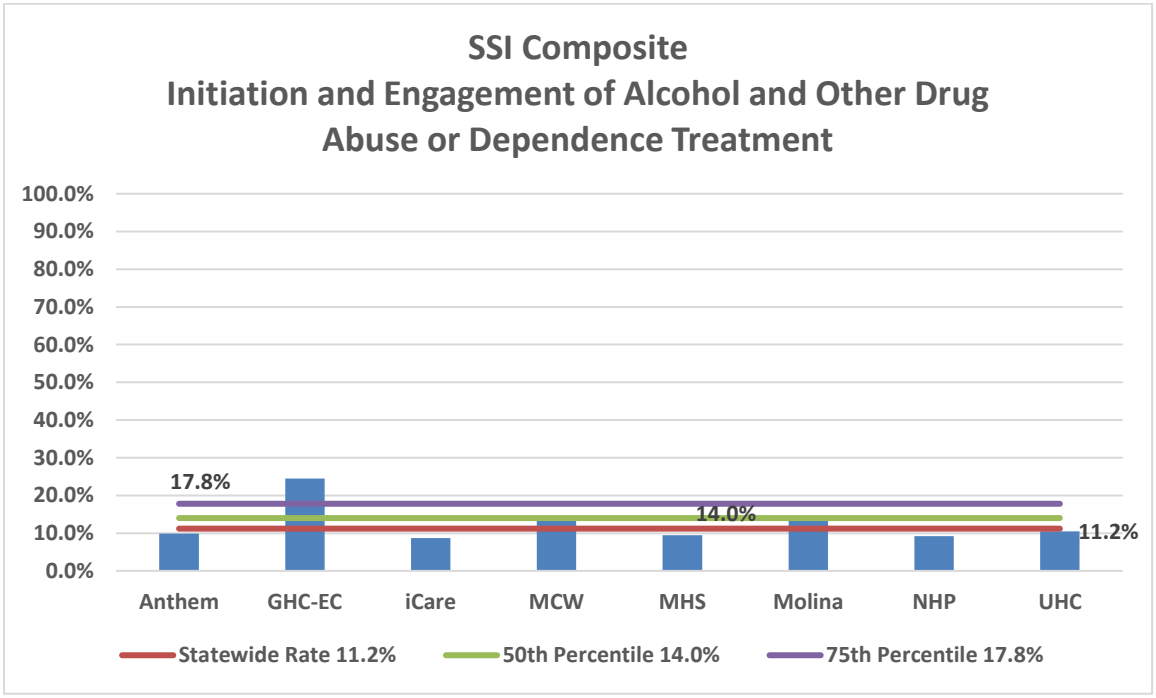


SSI Composite Measures

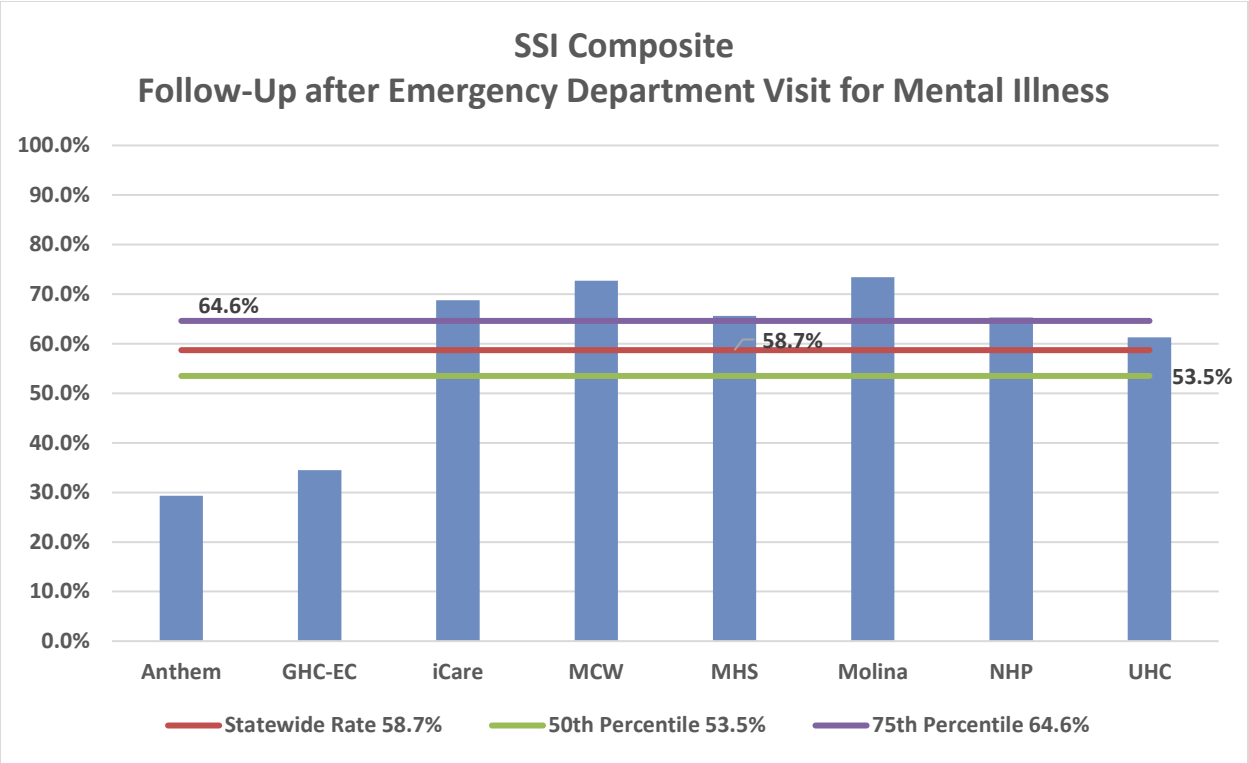
The following graph displays the results for Controlling Blood Pressure by MCO.



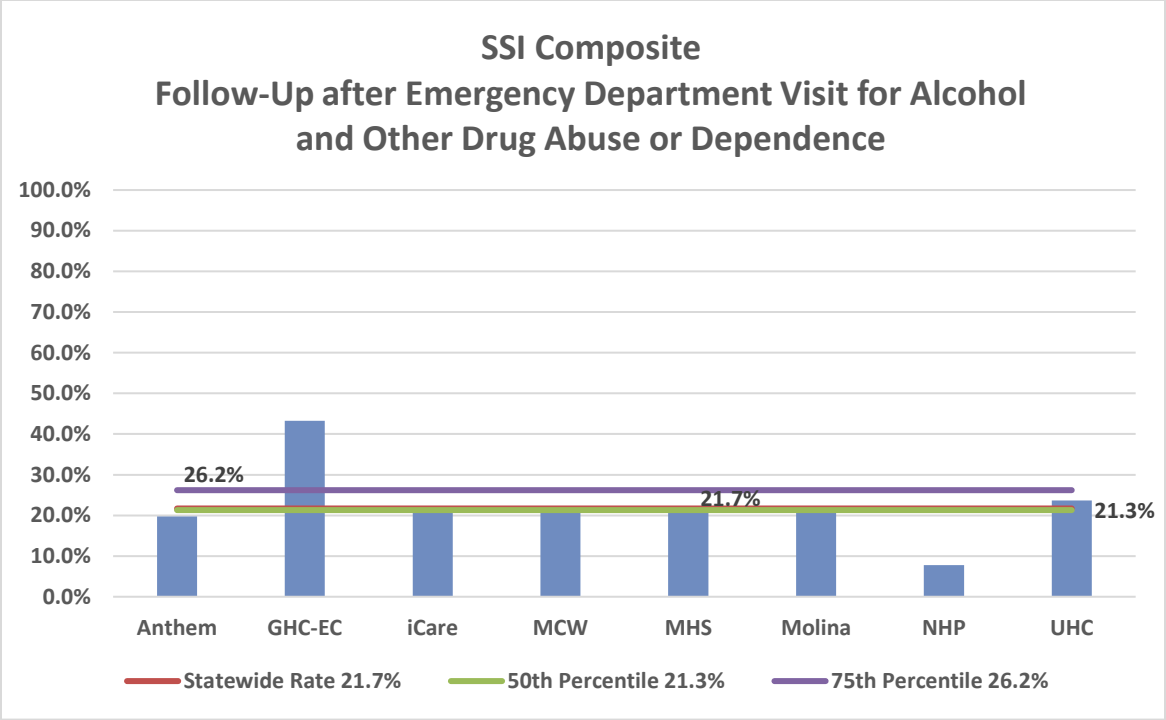
The graph below displays the results for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment by MCO.



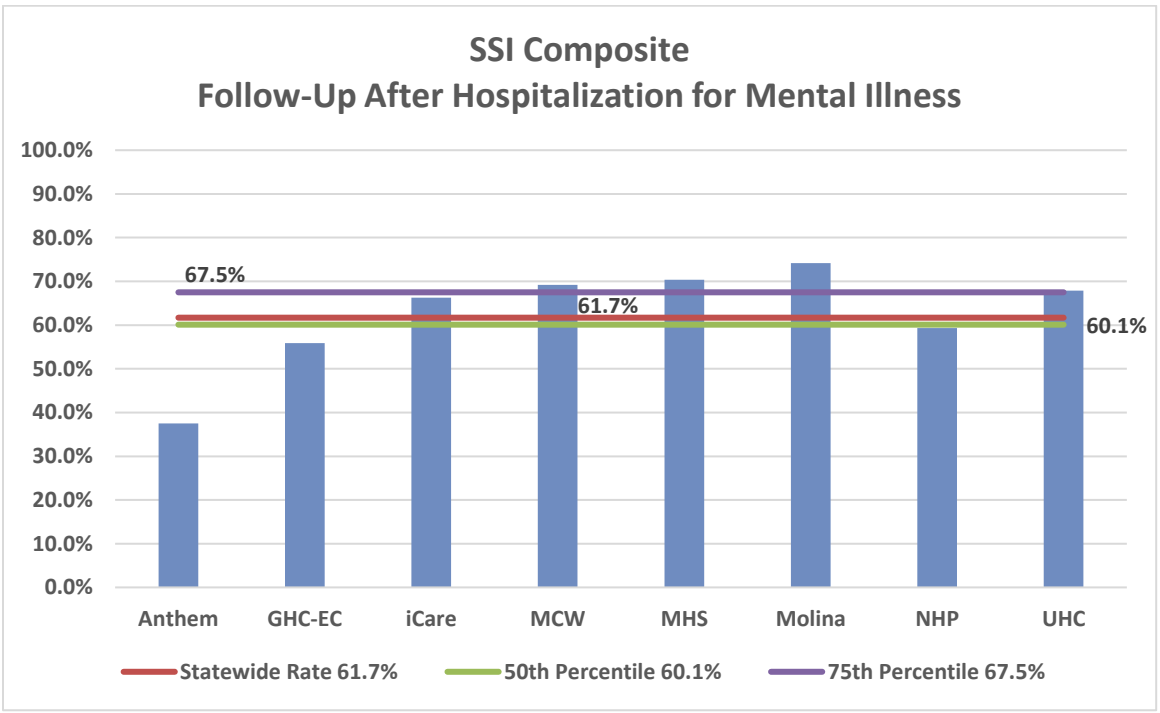
The graph below displays the Follow-Up after Emergency Department Visit for Mental Illness by MCO.



The following graph displays the Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence by MCO.



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



Analysis

The state rate was above the national 75th percentile for the Timeliness of Prenatal Care measure. Twelve of 14 BC+ MCOs exceeded the 75th percentile in this measure. The remaining two MCOs were below the 50th percentile.

For the PPC measure, the state rate was below the 50th percentile benchmark. The state rate for the measure was 74.7 percent. None of the 14 MCOs reached the 50th percentile.

One of 14 MCOs was above the 75th percentile for the CIS measure. Two were above the 50th percentile while 11 were below the national benchmarks for this measure.

Nine of 14 MCOs were at or above the 50th percentile for the IMA measure. Five MCOs were below the 50th percentile. The statewide rate was above the 50th percentile.

Six of the 14 BC+ MCOs were above the 75th percentile for the LSC measure. Seven of the 14 MCOs were above the 50th percentile. One MCO was below both the national benchmarks and lower than the statewide rate.

Four of eight SSI MCOs exceeded the 75th percentile for the CBP measure. Two MCOs were above the 50th percentile. The remaining two MCOs were below the 50th percentile. All MCOs were above the statewide rate of 61.6 percent.

One of the SSI MCOs exceeded the 75th percentile for the IET measure. One of eight MCOs was above the 50th percentile. Six MCOs were below the 50th percentile. The statewide rate was 11.2 percent, below the national benchmark.

Five of eight MCOs exceeded the 75th percentile for the FUM-30 measure. One MCO was above the 50th percentile. The remaining two MCOs were below the 50th percentile as well as below the statewide rate of 58.7 percent.

One of eight MCOs was above the 75th percentile for the FUA-30 measure. Five SSI MCOs were at or above the 50th percentile. Two MCOs were below the 50th percentile as well as the statewide rate of 21.7 percent.

Four of the eight SSI MCOs were above the 75th percentile for the FUH-30 measure. One MCO was below the 50th percentile. Three MCOs were below the 50th percentile and statewide rate of 60.1 percent.

Conclusions

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

PROTOCOL 3: COMPLIANCE WITH STANDARDS – QUALITY COMPLIANCE REVIEW

Compliance with Standards 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.

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.

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;
- Availability and use of Home and Community Based Wavier Services as alternatives to institutional care, so individuals can receive the services they need in the most integrated setting appropriate;
- Credentialing or other selection processes for providers; and
- Person-centered assessment, person-centered care planning, service planning and authorization, services coordination, and care management.

The compliance with standards review was revised at the start of this calendar year to align with the CMS EQR Protocol, which defines the review activities for Medicaid Managed Care Programs and Prepaid Inpatient Health Plans. The revision to the review changed the scoring process, making the numeric scores from prior reviews not comparable to the current review.

The review is divided into three focus areas or groups of standards:

MCO Standards which include provider network, care management, and enrollee rights:

- Disenrollment requirements and limitations 42 CFR 438.56
- 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

Overall Results by MCO

Compliance is expressed in terms of a percentage score and rating, as identified in the table below. See Appendix 2 for more information about the scoring methodology.

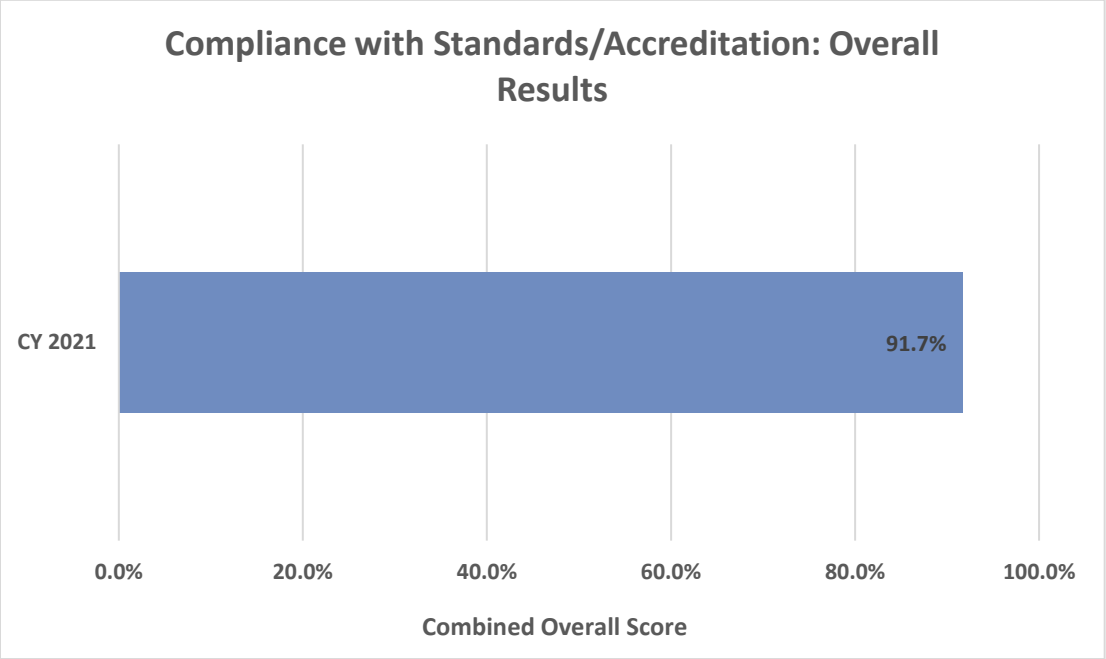
Scoring Legend	
Percentage Met	**Rating**
90.0% - 100.0%	EXCELLENT
80.0% - 89.9%	VERY GOOD
70.0% - 79.9%	GOOD
60.0% - 69.9%	FAIR
< 60.0%	POOR

MetaStar conducted three Compliance with Standards reviews during CY 2021 for MCOs that are not accredited by NCQA. In addition, MetaStar conducted 11 accreditation desk reviews for MCOs holding NCQA Accreditation. The following graphs indicate the MCOs' overall level of compliance in the CY 2021 Compliance with Standards review.

For all MCOs, the statewide overall compliance score is 91.7 percent, and a rating of Excellent. The table below indicates the overall level of compliance with each one of the focus areas of standards comprising the Compliance with Standards review in this reporting period.

MCO Compliance with Standards Review CY 2021			
Focus Area	**Scoring Elements**	**Percentage**	**Rating**
MCO Standards	1,166/1,256	92.8%	EXCELLENT
QAPI	214/224	95.5%	EXCELLENT
Grievance Systems	567/644	88.0%	VERY GOOD
Overall	**1,947/2,214**	**91.7%**	**EXCELLENT**

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



The definition of a scoring element rated as compliant can be found in Appendix 2 which includes the full implementation of written policies and procedures, and ongoing monitoring. MetaStar used the retrospective review period of 12 months prior to each MCO's Compliance with Standards 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 3 includes results for each standard by MCO.

Results for Compliance with Standards Review Focus Area - MCO Standards

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;
- Coordination and continuity of member care;
- Timely authorization of services and issuance of notices to members; and
- Compliance with other requirements.

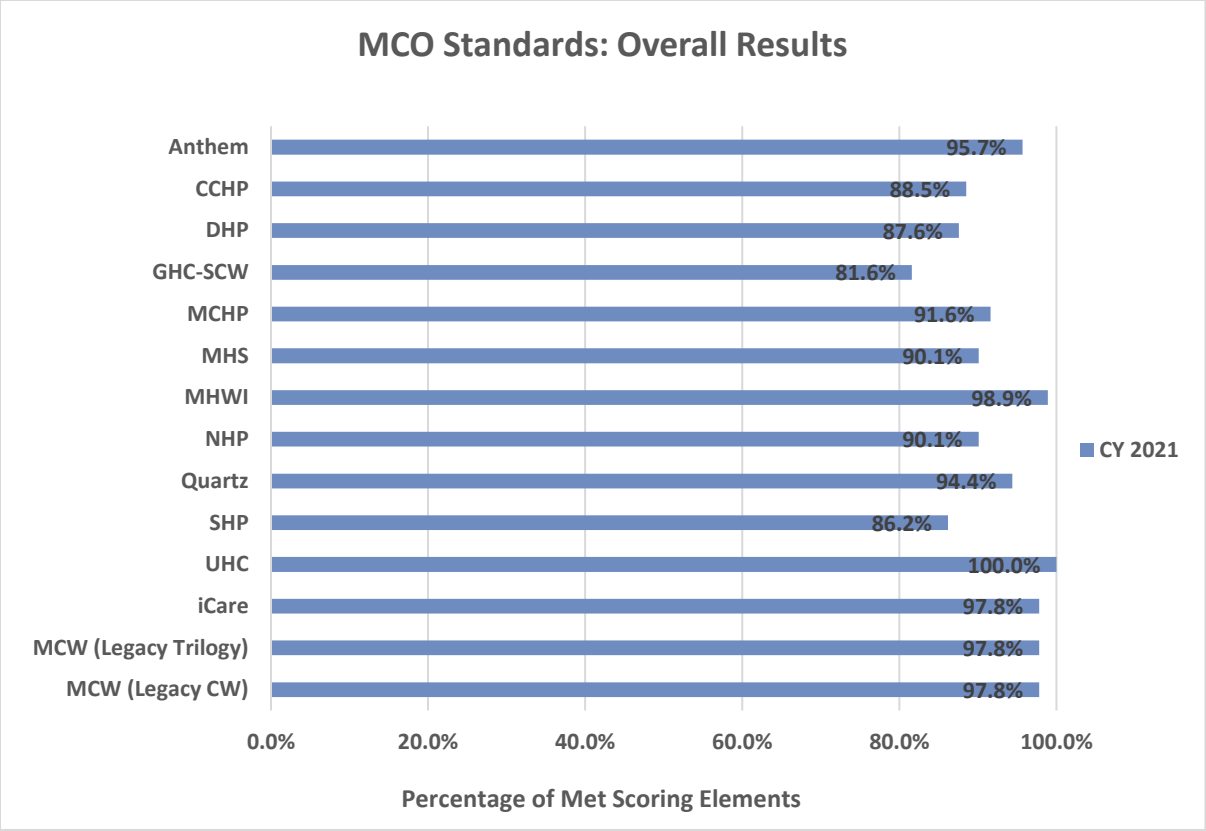
MCOs are also responsible to help members understand their rights as well as to ensure those rights are protected. This requires an adequate organizational structure and sound processes that adhere to federal and state requirements, and are capable of ensuring that members' rights are protected.

For all MCOs, the statewide MCO Standards compliance score is 92.8 percent, and a rating of Excellent. The table below indicates the overall level of compliance with the MCO Standards in this calendar year.

MCO Standards: Provider Network, Care Management, and Enrollee Rights			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M1	81/98	82.7%	VERY GOOD
M2	95/98	96.9%	EXCELLENT
M3	42/42	100.0%	EXCELLENT
M4	87/98	88.8%	VERY GOOD
M5	83/84	98.8%	EXCELLENT
M6	70/70	100.0%	EXCELLENT
M7	127/140	90.7%	EXCELLENT
M8	92/112	82.1%	VERY GOOD
M9	154/154	100.0%	EXCELLENT
M10	41/42	97.6%	EXCELLENT
M11	48/56	85.7%	VERY GOOD
M12	14/14	100.0%	EXCELLENT
M13	134/147	91.2%	EXCELLENT
M14	58/59	98.3%	EXCELLENT
M15	40/42	95.2%	EXCELLENT
M16*	NA	NA	NA
Overall	**1,166/1,256**	**92.8%**	**EXCELLENT**

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

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



Observation and Analysis: MCO Standards, Provider Network

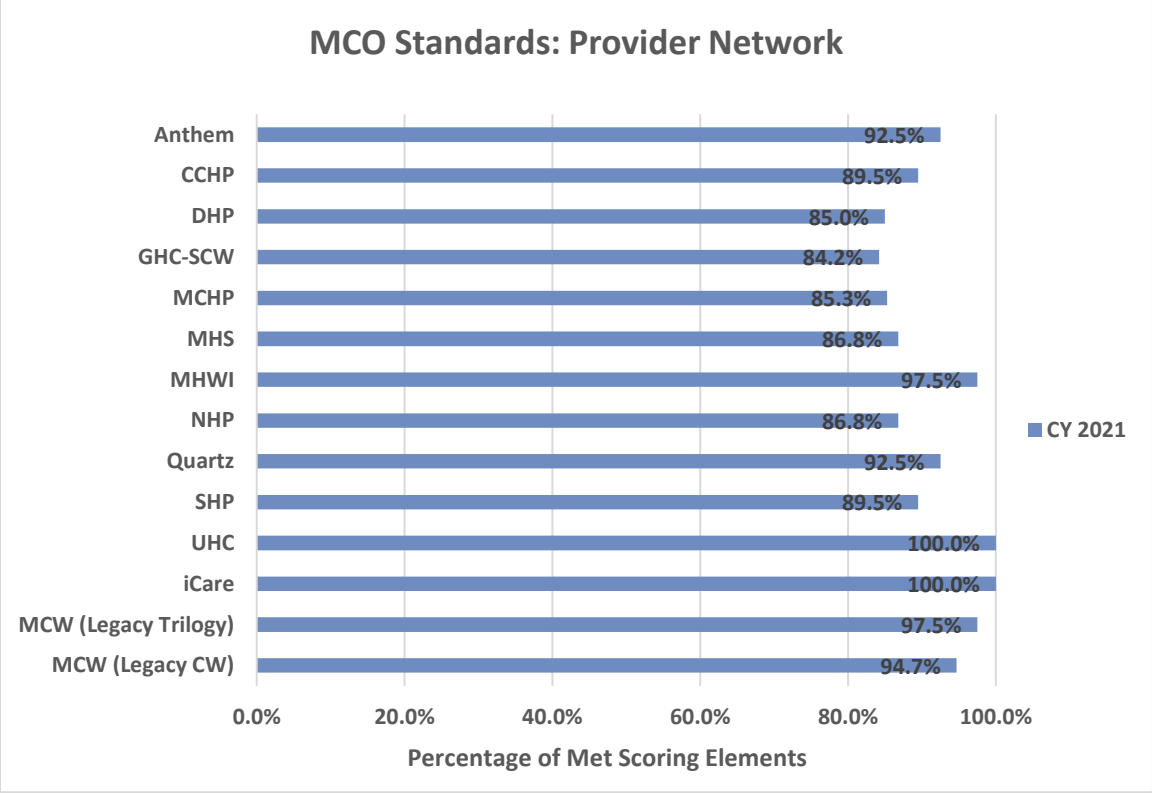
MCOs must provide members timely access to high quality long-term care and health care services by developing and maintaining the structure, operations, and processes to ensure availability of accessible, culturally competent services through a network of qualified service providers. Six standards address requirements related to availability of services, provider selection, sub-contractual/provider relationships, and delegation.

For all MCOs, the statewide MCO Standards, Provider Network compliance score is 91.7 percent, and a rating of Excellent. The following table indicates the overall level of compliance with the MCO Standards, Provider Network standards in this calendar year.

MCO Standards: Provider Network			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M1	81/98	82.7%	VERY GOOD
M2	95/98	96.9%	EXCELLENT
M3	42/42	100.0%	EXCELLENT
M4	87/98	88.8%	VERY GOOD
M13	134/147	91.2%	EXCELLENT
M14	58/59	98.3%	EXCELLENT

MCO Standards: Provider Network			
Standard	**Scoring Elements**	**Percentage**	**Rating**
Overall	**497/542**	**91.7%**	**EXCELLENT**

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



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, contains seven scoring elements for each MCO, for a total of 98 scoring elements. The MCOs satisfied requirements for 81 out of 98 scoring elements, for a score of 82.7 percent, and a rating of Very Good.

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 member to obtain one outside the network, at no cost to the member. Four MCOs did not meet this scoring element as policies and procedures did not identify that there would be no cost to the member for obtaining a second opinion from an in-network or out-of-network provider.

Scoring element M1.4 requires MCOs to adequately and timely cover services with non-network providers if the PIHP's network is unable to provide the covered necessary services. Five MCOs

did not meet this scoring element regarding the length of time services from out-of-network providers will be authorized.

Scoring element M1.5 requires out-of-network providers to coordinate with the MCO for payment to ensure the cost to the member is no great than it would be if the services were furnished within the network. Seven MCOs did not meet this scoring element as policies and procedures did not include this assurance.

Scoring element M1.7 requires MCOs to demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services. One MCO did not satisfy this scoring element as its policy in place to monitor the availability of practitioners and accessibility of services did not demonstrate this assurance.

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

To ensure timely access to care and services, MCOs require providers to meet state standards. MCOs must monitor compliance, and take corrective action if needed. The standard, M2, contains seven scoring elements for each MCO, for a total of 98 scoring elements. The MCOs satisfied requirements for 95 out of 98 scoring elements, for a score of 96.8 percent, and a rating of Excellent.

Scoring element M2.2 requires MCOs to ensure its network providers offer hours of operation that are no less than the hours of operation offered to commercial members and Medicaid fee-for-service, if the provider serves only Medicaid members. One MCO did not satisfy the requirements for this scoring element as its provider manual did not clearly specify this requirement and expectation to providers.

Scoring element M2.6 requires MCOs to take corrective action against a provider if there is a failure to comply with timely access to care and services. Two MCOs did not satisfy the requirements for this scoring element as their policies and procedures did not address corrective action if providers fail to meet State defined access standards.

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

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, contains three scoring elements for each MCO, for a total of 42 scoring elements. The MCOs satisfied requirements for 42 out of 42 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

All MCOs demonstrated efforts to ensure cultural diversity, including diversity trainings for organizational staff, translation of documents into different languages, coordination of interpreter

services for members, incorporation of cultural preferences into assessments, and educational materials for providers. All MCOs satisfied requirements for this standard.

M4 Network adequacy - 42 CFR 438.207

MCOs must ensure its delivery network is sufficient to provide adequate access to all services. The standard, M4, contains seven scoring elements for each MCO, for a total of 98 scoring elements. The MCOs satisfied requirements for 87 out of 98 scoring elements, for a score of 88.8 percent, and a rating of Very Good.

Scoring element M4.1 requires MCOs to ensure its delivery network is sufficient to provide adequate access to all services based on the anticipated BC+ or SSI enrollment. Seven MCOs did not satisfy the requirement for this scoring element as policies and procedures did not explain the processes for how the MCOs anticipate enrollment or utilize this information to ensure its network is adequate.

Scoring element M4.2 requires MCOs to evaluate the adequacy of the network based on expected utilization of services, considering member characteristics and health care needs. One MCO did not satisfy the requirement for this scoring element as policies and procedures did not detail the process for how the MCO considers expected utilization of services when monitoring the adequacy of the network.

Scoring element M4.6 requires MCOs to determine whether providers are physically accessible, and provide reasonable accommodations and accessible equipment for members with physical or mental disabilities. Two MCOs did not satisfy the requirement for this scoring element as the MCOs detailed a self-reporting process for providers without a verification process in place to confirm compliance.

Scoring element M4.7 requires MCOs to determine whether providers have the ability to communicate with limited English proficient members in their preferred language. One MCO did not satisfy this requirement as its policies and procedures did not identify how the MCO obtains information on alternate language capacity of providers to ensure network adequacy.

M13 Provider selection - 42 CFR 438.214

The MCO must have a written process for the selection and periodic evaluation of qualified providers. The MCO is responsible for ensuring all applicable provider requirements are met at initial contracting and throughout the duration of the contract. The standard, M13, contains 10 scoring elements for MCOs that do not delegate selection of providers to another entity, and 11 scoring elements for MCOs that delegate this function, for a total of 147 scoring elements. The MCOs satisfied requirements for 134 out of 147 scoring elements, for a score of 91.2 percent, and a rating of Excellent.

Scoring element M13.3 requires MCOs to implement provider network selection policies and procedures that do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. In addition, if MCOs decline to include groups of providers in their network, they must give the affected providers written notice of the reason for its determination. Three MCOs did not satisfy requirements for this scoring element as documentation ensuring non-discrimination was not specific to providers serving high-risk populations or specializing in conditions that require costly treatment.

Scoring element M13.10 states the MCO must immediately submit to DHS (and other entities as required) the names of any providers excluded from the network for quality concerns. Ten MCOs did not satisfy the requirements for this scoring element as they either did not identify they would notify DHS of any identified excluded or prohibited providers, or the timeframe for notifying DHS was not noted as immediate notification.

M14 Subcontractual relationships and delegation - 42 CFR 438.230

The MCO must oversee and be accountable for functions and responsibilities that it delegates to any subcontractor/provider. The MCO must monitor the subcontractor/provider's performance, and take corrective action if needed. The standard, M14, contains four scoring elements for MCOs that do not delegate selection of providers to another entity, and five scoring elements for MCOs that delegate this function, for a total of 59 scoring elements. One organization did not delegate any functions or responsibilities to any subcontractor or provider, and M14 was not applicable to this organization. The MCOs satisfied requirements for 58 out of 59 scoring elements, for a score of 98.3 percent, and a rating of Excellent.

Scoring element M14.2 requires the MCO to evaluate the prospective subcontractor's ability to perform the activities to be delegated prior to any delegation. One MCO did not satisfy the requirements for this scoring element as its vendor contracting policy did not describe the process related to how the MCO researches the prospective subcontractor to assure they can perform the activities to be delegated.

Observation and Analysis: MCO Standards, Care Management

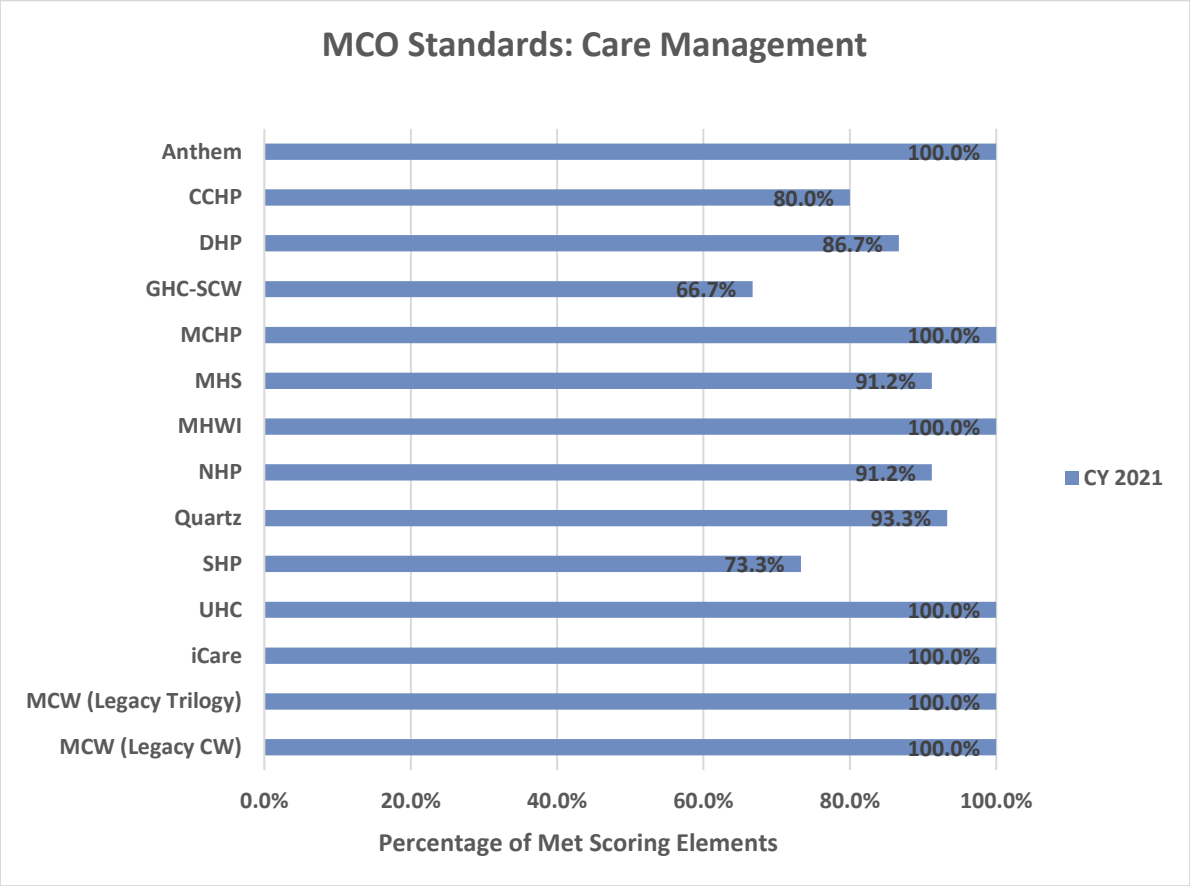
MCOs must provide members timely access to high quality long-term care and health care services by developing and maintaining the structure, operations, and processes to ensure coordination and continuity of member care, timely authorization of services, and issuance of notices to members. Five standards address requirements related to coordination and continuity of care, and coverage and authorization of services.

For all MCOs, the statewide MCO Standards, Care Management compliance score is 92 percent, and a rating of Excellent. The table on the following page indicates the overall level of compliance with the MCO Standards, Care Management standards in this calendar year.

MCO Standards: Care Management			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M5	83/84	98.8%	EXCELLENT
M6	70/70	100.0%	EXCELLENT
M7	127/140	90.7%	EXCELLENT
M8	92/112	82.1%	VERY GOOD
M15	40/42	95.2%	EXCELLENT
M16*	NA	NA	NA
Overall	**412/448**	**92.0%**	**EXCELLENT**

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

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



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 MCO must implement procedures to deliver care to and coordinate services for all MCO

members (M5). The standard, M5, contains six scoring elements for each MCO, for a total of 84 scoring elements. The MCOs satisfied requirements for 83 out of 84 scoring elements, for a score of 98.8 percent, and a rating of Excellent.

Scoring element M5.1 requires MCOs to ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. Members must be provided information on how to contact their designated person or entity, and the MCO must ensure that every member has a primary care provider (PCP) or a primary care clinic responsible for coordinating the services accessed by the member. In addition, the process must include a defined method to notify the member of their PCP and how to contact the provider. One MCO did not satisfy the requirements for this scoring element as its policies and procedures did not include a mechanism to notify the member of how to contact their PCP if one is assigned to them.

MCOs 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, contains three scoring elements for each MCO that operates the BC+ program, and seven scoring elements for each MCO that operates the SSI program, for a total of 70 scoring elements. The MCOs satisfied requirements for 70 out of 70 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

All MCOs had processes in place to effectively assess members and identify ongoing needs requiring referrals to case management if needed. MCOs serving SSI members had mechanisms in place to use information gathered during the assessment to stratify members for care management contact purposes and develop care plans. Each MCO satisfied requirements for this standard.

M7 Disenrollment: requirements and limitations - 42 CFR 438.56

MCOs must comply with requirements for member disenrollment. The standard, M7, contains 10 scoring elements for each MCO, for a total of 140 scoring elements. The MCOs satisfied requirements for 127 out of 140 scoring elements, for a score of 90.7 percent, and a rating of Excellent.

Scoring element M7.7 identifies the acceptable reasons for system based disenrollments including loss of eligibility, move out of the service area, loss of Medicare eligibility for BC+ members, if a member is an inmate of a public institution, and if a member was participating in a county case management waiver program or other managed care program. Three MCOs did not satisfy requirements for this scoring element as policies and procedures did not address reasons for system based disenrollments other than move out of the service area.

Scoring element M7.8 requires MCOs to submit involuntary disenrollment requests to DHS and include evidence attesting to cause. Four MCOs did not satisfy the requirements for this scoring element as they did not provide evidence of a policy or procedure to address involuntary disenrollment requests by the MCO to DHS.

Scoring element M7.9 requires MCOs to provide prompt written notification and proof of the change in member circumstance to DHS related to a move outside the MCO's service area or death of a member. Four MCOs did not satisfy the requirements for this scoring element as they did not provide evidence of a policy or procedure to address disenrollments due to changes in member circumstance.

Scoring element M7.10 identifies exemptions from MCO enrollment, and specifies that exemption requests must come from the member, the member's family, or legal guardian. Two MCOs did not satisfy requirements for this scoring element as they did not provide evidence of a policy or procedure to address enrollment exemptions.

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, contains eight scoring elements for each MCO, for a total of 112 scoring elements. The MCOs satisfied requirements for 92 out of 112 scoring elements, for a score of 82.1 percent, and a rating of Very Good.

Scoring element M8.3 requires MCOs to provide notice on standard authorization decisions as expeditiously as the member's condition requires and within State-established timeframes that may not exceed 14 calendar days following the receipt of the request for service. An extension of up to 14 additional calendar days is possible if the member or provider requests the extension or if the MCO justifies a need for additional information and how the extension is in the member's interest. Four MCOs did not satisfy requirements for this scoring element as policies and procedures did not reflect extensions to the standard decision-making timeframe upon request of members and/or providers.

Scoring element M8.4 identifies that when a provider indicates, or the MCO determines, that following the standard decision-making timeframe could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the MCO is required to make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. An extension of up to 14 additional calendar days is possible if the member or provider requests the extension or if the MCO justifies a need for additional information and how the extension is in the member's interest. Five MCOs did not satisfy requirements for this scoring element as

policies and procedures did not reflect extensions to the expedited decision-making timeframe upon request of members and/or providers.

Scoring element M8.5 specifies MCOs are responsible for coverage and payment of emergency services and post-stabilization care services. Two MCOs did not satisfy requirements for this scoring element as they did not provide evidence of post-stabilization of care policies and procedures.

Scoring element M8.6 identifies that MCOs may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP or MCO of the member's screening or treatment within 10 calendar days of presentation for emergency services. One MCO did not satisfy the requirements of this scoring element as its out-of-area care policy reflected limitations for coverage, and noted coverage is only available for members accessing emergency services that are located more than 50 miles from the MCO's nearest clinic or contracted clinic/facility.

Scoring element M8.7 prohibits MCOs from holding members with an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. Two MCOs did not satisfy the requirements of this scoring element as this information was not included in the MCOs' policies and procedures.

Scoring element M8.8 specifies that the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. Six MCOs did not satisfy the requirements of this scoring element as their policies and procedures did not specify the person responsible for determining when the member is sufficiently stabilized for transfer or discharge.

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, contains three scoring elements for each MCO, for a total of 42 scoring elements. The MCOs satisfied requirements for 40 out of 42 scoring elements, for a score of 95.2 percent, and a rating of Excellent.

Scoring element M15.2 requires MCOs to disseminate practice guidelines to all providers, and upon request to members and potential members. Two MCOs did not satisfy this requirement as clinical practice guideline policies and procedures did not address the requirement to disseminate the guidelines to members upon request.

M16 Health information systems – 42 CFR 438.242

MCOs must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization,

grievances and appeals, and disenrollment, for other than loss of Medicaid eligibility. This standard is evaluated as part of the MCOs' ISCA, conducted once every three years. The ISCA occurs separate from the Compliance with Standards review.

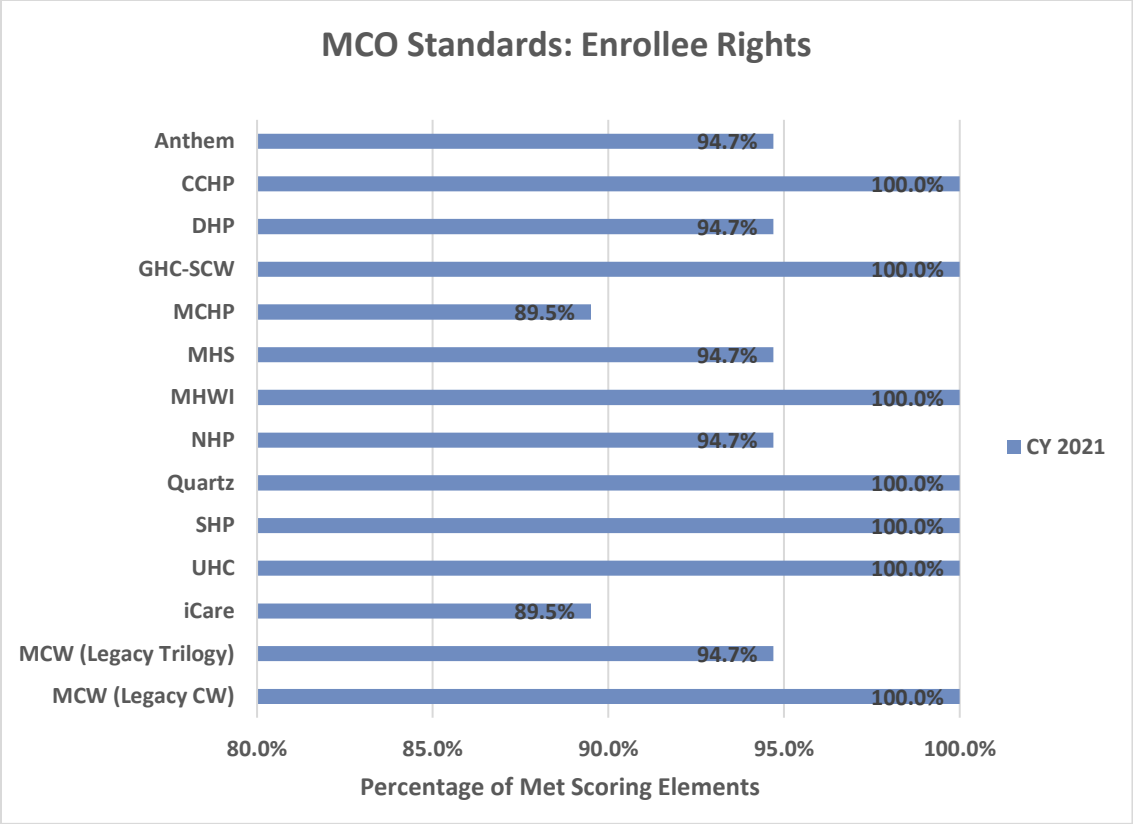
Observation and Analysis: MCO Standards, Enrollee Rights

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.

For all MCOs, the statewide MCO Standards, Enrollee Rights compliance score is 96.6 percent, and a rating of Excellent. The table below indicates the overall level of compliance with the MCO Standards, Enrollee Rights standards in this calendar year.

MCO Standards: Enrollee Rights			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M9	154/154	100.0%	EXCELLENT
M10	41/42	97.6%	EXCELLENT
M11	48/56	85.7%	VERY GOOD
M12	14/14	100.0%	EXCELLENT
Overall	**257/266**	**96.6%**	**EXCELLENT**

The graph on the following page illustrates each MCO's overall compliance with these standards.



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

Organizations are required to provide readily accessible written information to members in a manner and format that is easily understood. The standard, M9, contains 11 scoring elements for each MCO, for a total of 154 scoring elements. The MCOs satisfied requirements for 154 out of 154 scoring elements, for a score of 100 percent, and a rating of Excellent.

Organizations provide members with written materials in a manner and format that is easily understood. All MCOs demonstrated that member materials can be provided in alternative formats and languages when needed. Safeguards have been implemented along with a consent process when members request materials in an electronic format. All MCOs demonstrated that required new member materials are provided to members in a timely manner, including the most up to date member handbook. All MCOs satisfied requirements for 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, contains three scoring elements for each MCO, for a

total of 42 scoring elements. The MCOs satisfied requirements for 41 out of 42 scoring elements, for a score of 97.6 percent, and a rating of Excellent.

Scoring element M10.2 specifies that MCOs may not prohibit, or otherwise restrict, a provider from acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his/her patient regarding health status, medical care, treatment options, and the right to refuse treatment. One MCO did not satisfy the requirements of this scoring element as MCO policies and procedures did not provide this assurance.

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 are required to have written policies and procedures for member rights and advance directives, which include the right to participate in decisions regarding his or her care, the right to refuse treatment, and the right to be free from any form of restraint. The standard, M11, contains four scoring elements for each MCO, for a total of 56 scoring elements. The MCOs satisfied requirements for 48 out of 56 scoring elements, for a score of 85.7 percent, and a rating of Very Good.

Scoring element M11.1 requires MCOs to have written policies guaranteeing each member's rights, and share those written policies with staff and affiliated providers. Two MCOs did not satisfy requirements for this scoring element. One MCO did not provide documentation to confirm the MCO had a written member rights policy, and one MCO did not demonstrate a mechanism to share written member rights policies with affiliated providers.

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 used as a means of coercion, discipline, convenience, or retaliation. Four MCOs did not satisfy requirements for this scoring element as they did not provide evidence of written policies and procedures related to restraints and restrictive measures.

Scoring element M11.4 requires MCOs to provide education to staff and the community on issues concerning advance directives. Two MCOs did not satisfy requirements for this scoring element as policies and procedures did not incorporate mechanisms to provide the required community education about advance directives.

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

The MCO must comply with all applicable Federal and State laws for the protection of member rights. The standard, M12, contains one scoring element for each MCO, for a total of 14 scoring elements. The MCOs satisfied requirements for 14 out of 14 scoring elements, for a score of 100 percent, and a rating of Excellent.

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

Results for Compliance with Standards Review Focus Area – Quality Assessment and Performance Improvement

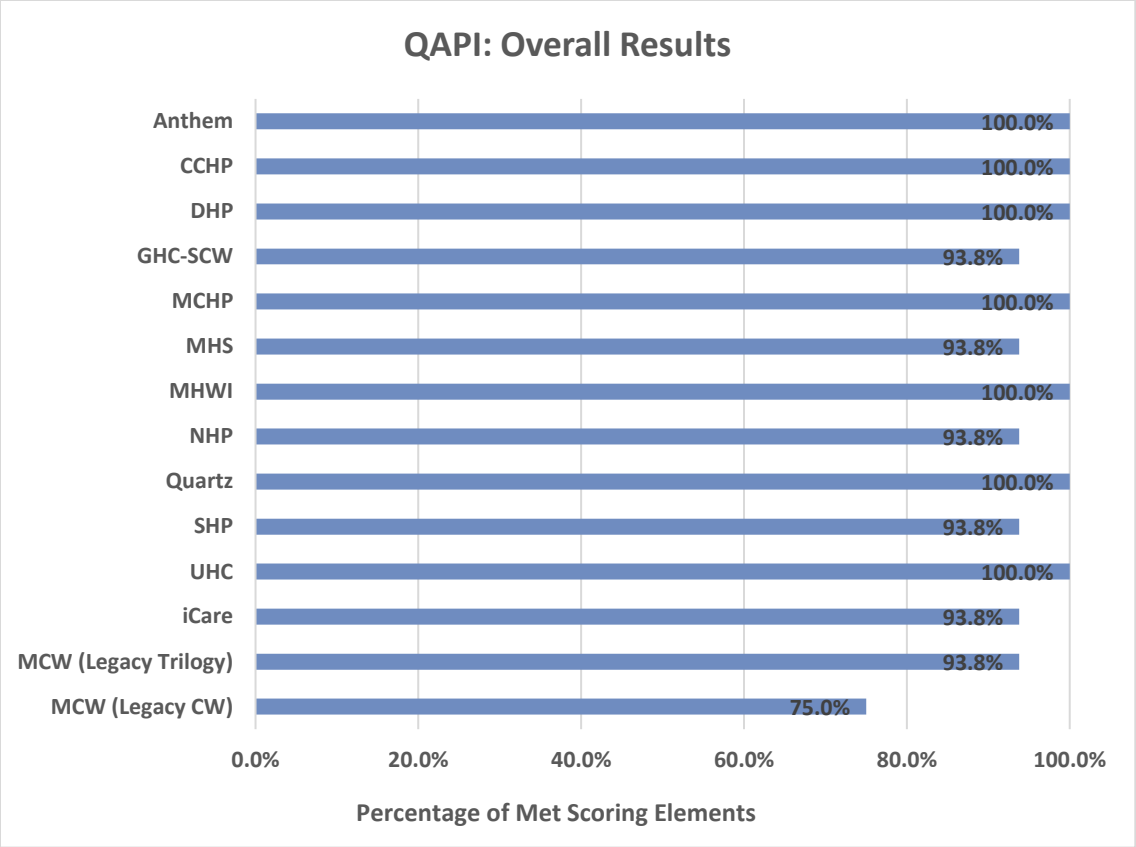
MCOs must provide members timely access to high quality health care services by developing and maintaining the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement (QAPI).

For all MCOs, the statewide QAPI compliance score is 95.5 percent, and a rating of Excellent. The table below indicates the overall level of compliance with the QAPI standards in this calendar year.

Quality Assessment and Performance Improvement			
Standard	**Scoring Elements**	**Percentage**	**Rating**
Q1	123/126	97.6%	EXCELLENT
Q2	78/84	92.9%	EXCELLENT
Q3*	NA	NA	NA
Q4*	NA	NA	NA
Q5	13/14	92.9%	EXCELLENT
Overall	**214/224**	**95.5%**	**EXCELLENT**

*Q3 is evaluated as part of the MCOs' Validation of Performance Measures activity, which is conducted on a different cycle than the Compliance with Standards Review. *Q4 is evaluated as part of the MCOs' Validation of Performance Improvement Projects activity, which is conducted on a different cycle than the Compliance with Standards Review.

The graph on the following page illustrates each MCO's overall compliance with these standards.



OBSERVATION AND ANALYSIS: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Q1 Quality assessment program – 42 CFR 438.330(a)

The MCO must establish and implement an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members. The QAPI program must meet minimum requirements outlined in the DHS-MCO contract related to its administrative structures, stakeholder participation, quality work plan, and monitoring activities. The standard, Q1, contains nine scoring elements for each MCO, for a total of 126 scoring elements. The MCOs satisfied requirements for 123 out of 126 scoring elements, for a score of 97.6 percent, and a rating of Excellent.

Scoring element Q1.3 requires an interdisciplinary QAPI committee membership; made up of both providers and administrative staff of the MCO, including qualified professionals specializing in mental health, substance abuse, and dental care on a consulting basis when issues related to these areas arise. Two MCOs did not satisfy the requirements for this scoring element as the membership of the quality committees did not specify the use of mental health, substance abuse, and/or dental consultants as required.

Scoring element Q1.5 requires the MCO to have a system to receive member input on quality improvement, document the input received along with the MCO's response to the input, and include a description of any changes it implemented as a result of the input. One MCO did not satisfy the requirements for this scoring element as it did not incorporate a mechanism to analyze and address member input as part of the quality program.

Q2 Quality assessment work plan – 42 CFR 438.330(b)

The comprehensive quality assessment and performance improvement program must, at a minimum, include mechanisms to detect underutilization and overutilization of services, assess the quality and appropriateness of care furnished to members, collect and submit performance improvement data, conduct performance improvement projects, and monitor and evaluate provider performance. The quality plan should outline the scope of activities, goals, objectives, timelines, responsible persons, and be based on findings from quality improvement efforts. The standard, Q2, contains six scoring elements for each MCO, for a total of 84 scoring elements. The MCOs satisfied requirements for 78 out of 84 scoring elements, for a score of 92.9 percent, and a rating of Excellent.

Scoring element Q2.1 requires MCOs' QAPI programs to include activities related to conducting performance improvement projects, collecting and submitting performance measurement data, implementing mechanisms to detect both under and overutilization of services, and assessing the quality and appropriateness of care furnished to members with special health care needs. Four MCOs did not satisfy the requirements for this scoring element as their QAPI programs did not incorporate a mechanism to detect both under and overutilization of services.

Scoring element Q2.3 requires the MCO to monitor and evaluate the quality of clinical care on an ongoing basis. One MCO did not satisfy the requirements for this scoring element as it was in the process of exploring options for metrics to enable the organization to review utilization data and identify trends related to the adequacy of the provider network.

Scoring element Q2.5 specifies that the MCO must monitor for and report to DHS all identified provider-preventable conditions. One MCO did not satisfy the requirements for this scoring element as documentation submitted did not identify routine monitoring and reporting to DHS occurred as required.

Q3 Performance measurement – 42 CFR 438.330(c)

MCOs must measure and report performance data on standard measures required by the DHS-MCO contract. This standard is evaluated as part of the MCOs' Validation of Performance Measures review, which is conducted and reported on a different cycle than the Compliance with Standards review.

Q4 Performance improvement – 42 CFR 438.330(d)

MCOs must conduct performance improvement projects designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. This standard is evaluated as part of the MCOs' Validation of Performance Improvement Project review, which is conducted and reported on a different cycle than the Compliance with Standards review.

Q5 Evaluation of the quality assessment program and work plan – 42 CFR 438.330(e)(2)

MCOs must develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program, and determine whether the program has achieved improvement in the quality of service provided to members. The standard, Q5, contains one scoring element for each MCO, for a total of 14 scoring elements. The MCOs satisfied requirements for 13 out of 14 scoring elements, for a score of 92.9 percent, and a rating of Excellent.

Scoring element Q5.1 requires the MCO to evaluate the overall effectiveness of its QAPI program annually. One MCO did not satisfy the requirements related to this scoring element as the overall effectiveness of the entire QAPI program was not fully described in its most recent annual evaluation, and the evaluation did not reflect data, analysis, or findings from several monitoring processes that were described in quality committee meeting minutes.

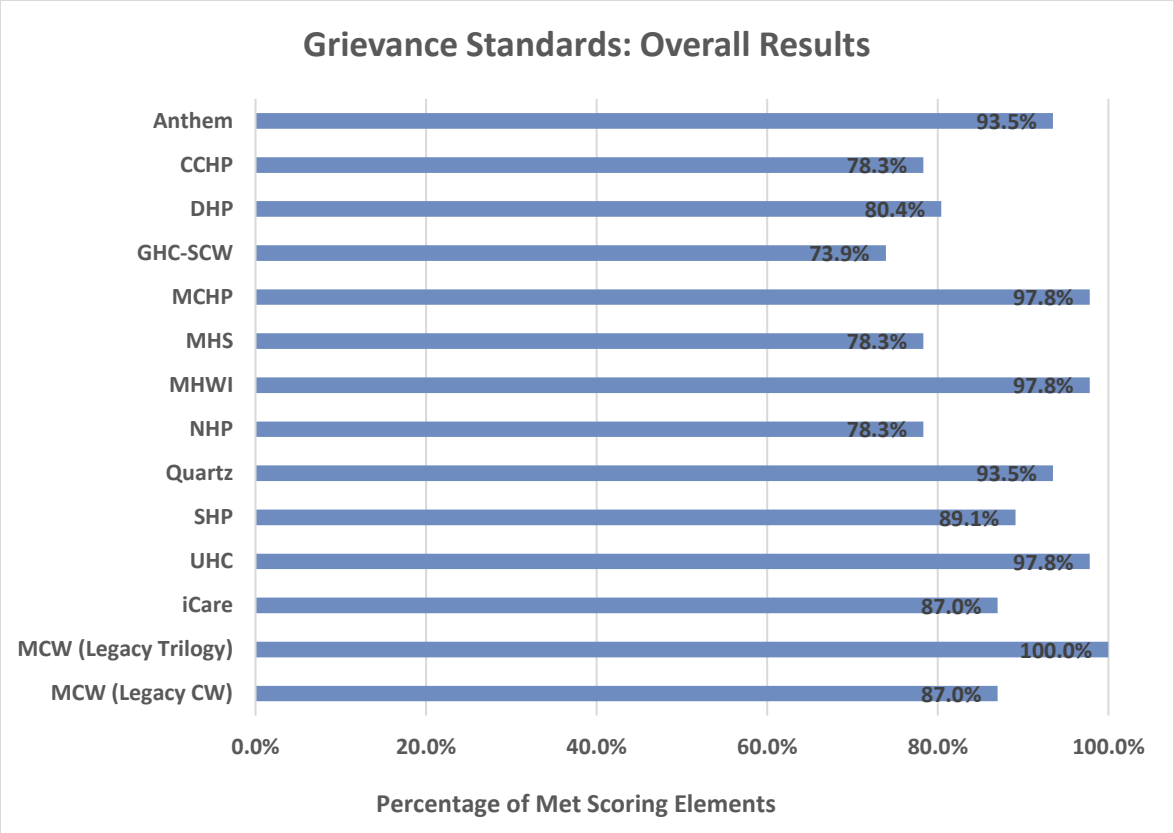
Results for Compliance with Standards Focus Area – Grievance Systems

MCOs must maintain an effective system for members to exercise their rights related to grievances and appeals.

For all MCOs, the statewide Grievance Systems compliance score is 88 percent, and a rating of Very Good. The table below indicates the overall level of compliance with the Grievance System standards in this calendar year.

Grievance Systems			
Standard	**Scoring Elements**	**Percentage**	**Rating**
G1	70/70	100.0%	EXCELLENT
G2	94/98	95.9%	EXCELLENT
G3	69/98	70.4%	GOOD
G4	28/28	100.0%	EXCELLENT
G5	163/182	89.6%	VERY GOOD
G6	41/42	97.6%	EXCELLENT
G7	3/14	21.4%	POOR
G8	25/28	89.3%	VERY GOOD
G9	52/56	92.9%	EXCELLENT
G10	22/28	78.6%	GOOD
Overall	**567/644**	**88.0%**	**VERY GOOD**

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



Observation and Analysis: Grievance Systems

G1 and G2 Grievance systems general requirements – 42 CFR 438.228, 42 CFR 438.402

MCOs must have a grievance and appeal system in place that includes an internal grievance process, an appeal process, and access to the state's Fair Hearing system (G1). The standard, G1, contains five scoring elements for each MCO, for a total of 70 scoring elements. The MCOs satisfied requirements for 70 out of 70 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

MCOs have policies in place detailing the organizations' processes for members to file grievances and appeals, and access to the state's Fair Hearing system. All MCOs satisfied requirements for this standard.

MCOs must accept grievances and appeals from members and their preferred representatives, including providers, with the member's written consent. MCOs must follow the state-specified timeframes associated with standard appeals. Additionally, members or member's legal decision makers, or anyone acting on the member's behalf with the member's permission, may file a grievance or appeal orally or in writing (G2). The standard, G2, contains seven scoring elements

for each MCO, for a total of 98 scoring elements. The MCOs satisfied requirements for 94 out of 98 scoring elements, for a score of 95.9 percent, and a rating of Excellent.

Scoring element G2.1 requires the MCO to have only one level of appeals for members. Three MCOs did not satisfy the requirements for this scoring element as their policies and procedures referenced more than one level of appeals within the organization or did not explicitly state there was only one level of appeals available to members within the organization.

Scoring element G2.5 states a member has 60 days from the date on the notice of adverse benefit determination to file the request for an appeal. One MCO did not meet the requirement for this scoring element as its grievances and appeals policy specified a shorter timeframe of only 45 days to file a request for an appeal.

G3 Notice to members – 42 CFR 438.404

Notices to members must be in writing and meet language and format requirements to ensure ease of understanding for members. The notices must be delivered to the member in the timeframes associated with each type of adverse decision. Additionally, if the MCO extends the timeframe for the decision making process, the member must receive a written notice of the reason for extension and inform the member of the right to grieve the extension. The standard, G3, contains seven scoring elements for each MCO, for a total of 98 scoring elements. The MCOs satisfied requirements for 69 out of 98 scoring elements, for a score of 70.4 percent, and a rating of Good.

Scoring element G3.1 describes the required contents of the written notice of adverse benefit determination provided to members. One MCO did not satisfy the requirements for this scoring element as the written notice did not include the member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

Scoring element G3.2 identifies the circumstances and timeframes for issuing notices for termination, suspension, or reduction of previously authorized Medicaid-covered services. Five MCOs did not satisfy the requirements for this scoring element as either the timeframe related to the issuance of notices did not align with the DHS-MCO contract requirements, or the MCOs did not provide evidence of policies or procedures related to issuing notices when a previously authorized service was terminated, suspended, or reduced.

Scoring element G3.3 requires notices to be issued for the denial of payment affecting a claim. Six MCOs did not satisfy the requirements for this scoring element as policies and procedures were not submitted to address this DHS-MCO contract requirement.

Scoring element G3.4 specifies the timeframe for MCOs to make standard authorization decisions that deny or limit services if the member or provider requested an extension, or if the MCO justified the need for additional information and how the extension was in the member's interest. Four MCOs did not satisfy the requirements for this scoring element as policies and procedures did not reflect extensions to the standard decision-making timeframe upon request of members and/or providers, or the timeframe related to making decisions no later than the date the extension expires.

Scoring element G3.5 states that if the MCO extends the timeframe for standard service authorization decisions, it must give the member written notice of the reason to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and to issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. Six MCOs did not satisfy the requirements for this scoring element as policies and procedures did not specify that members can file a grievance if they disagree with an extension to the initial service authorization decision-making timeframe, or the policies and procedures did not identify that the MCO would provide written notice to members when a service authorization request was denied.

Scoring element G3.6 requires notices to be issued for service authorization decisions not reached within the specified timeframes. Five MCOs did not satisfy the requirements for this scoring element as the policies and procedures did not identify that the MCO would provide written notice to members when a service authorization request was denied, or the MCOs did not identify the timeframe to issue the written notification of adverse benefit determination to members.

Scoring element G3.7 requires notices to be issued for expedited service authorization decisions not reached within the specified timeframes. Two MCOs did not satisfy the requirements for this scoring element as policies and procedures did not address the possibility of extending the expedited service authorization decision-making timeframe.

G4 Handling of grievances and appeals – 42 CFR 438.406

MCOs must give members any reasonable assistance in completing forms and taking other procedural steps in the grievance and appeal process. The MCO process must ensure individuals who make decisions on grievances and appeals, the grievance and appeal committee, have not been involved in any previous level of review or decision-making related to the issue. The committee must also include appropriate health care professionals. MCOs have special requirements for appeals which include written confirmation of grievances and appeals; the opportunity for members to present evidence and allegation of fact or law, in person or in writing; and provide members the opportunity to examine their records. The standard, G4, contains two scoring elements for each MCO, for a total of 28 scoring elements. The MCOs

satisfied requirements for 28 out of 28 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

MCO policies and procedures identify the organization's member advocate as being responsible for providing any assistance needed to navigate the MCO level grievance and appeal process. Policies outlined that acknowledgement of receipt of grievances and appeals are provided to members. The grievances and appeals committee, structure, and decision-making authority was clearly defined for each MCO. All MCOs satisfied requirements for this standard.

G5 Resolution and notification – 42 CFR 438.408

MCOs are required to have a system in place to dispose of grievances and appeals as expeditiously as the member's situation and health condition requires, within standard and expedited timeframes established in the DHS-MCO contract. The MCO or member may extend the timeframes for resolution of grievances and appeals. If the MCO requests the extension, it must provide the member with written notice of the reasons for the delay. Notice of resolution to members must be in writing and meet language and format requirements to ensure ease of understanding for members. The standard, G5, contains 13 scoring elements for each MCO, for a total of 182 scoring elements. The MCOs satisfied requirements for 163 out of 182 scoring elements, for a score of 89.6 percent, and a rating of Very Good.

Scoring element G5.1 specifies the timeframe requirements related to standard resolution of grievances, specific to issuing a written initial response and a written final response to the member. One MCO did not satisfy the requirements of this scoring element as policies and procedures did not address the provision of an initial response within 10 business days of receipt of a grievance.

Scoring element G5.3 requires the MCO to make reasonable effort to provide oral notice and issue a written disposition of an expedited hearing decision within 72 hours of receiving the oral or written request for expedited resolution. One MCO did not satisfy the requirements of this scoring element as the timeframe specified in the MCO's grievances and appeals policy did not align with the DHS-MCO contract requirement.

Scoring element G5.4 identifies that MCOs can extend grievance and appeal resolution timeframes by up to 14 calendar days if the member requests the extension or the MCO shows there is a need for additional information and how the delay is in the member's interest. Three MCOs did not satisfy the requirements of this scoring element as policies and procedures did not address instances where the member requested the extension to the grievance and appeal resolution timeframe.

Scoring element G5.5 outlines the notification requirements when the MCO extends the appeal resolution timeframe not at the request of the member. The MCO must make reasonable efforts

to give the member prompt oral notice and written notice within two calendar days. Three MCOs did not satisfy the requirements of this scoring element as policies and procedures did not specify the timeframes to provide written or oral notification to member when the MCO extends the appeal resolution timeframe.

Scoring element G5.6 states that if the MCO fails to adhere to the notice and timing requirements, the member is deemed to have exhausted the appeals process and a State Fair Hearing can be initiated. Two MCOs did not satisfy the requirements for this scoring element. The policies and procedures for one MCO did not address this requirement. Another MCO's policies and procedures identified members may bypass the MCO's formal appeals process and opt for a State Fair Hearing if internal review, negotiation, and or mediation with the MCO cannot resolve the appeal.

Scoring element G5.7 specifies that the format and language of the written notice of a grievance resolution must comply with the standards described in the *HMO & MCO Communication, Outreach, and Marketing Guide.* Two MCOs did not satisfy requirements for this scoring element as policies and procedures did not describe or provide evidence of the content or format of the written grievance resolution letter.

Scoring element G5.9 specifies the required content of the written appeal resolution notification letter. One MCO did not satisfy the requirements of this scoring element as policies and procedures did not identify that the appeal resolution letter includes a statement that the member may be held liable for the cost of continuing benefits if the State Fair Hearing decision upholds the MCO's adverse benefit determination.

Scoring element G5.10 identifies a member may request a State Fair Hearing only after exhausting the MCO's local process, and receiving notice that the MCO is upholding the adverse benefit determination. One MCO did not satisfy the requirements for this scoring element as policies and procedures identified members may bypass the MCO's formal appeals process and opt for a State Fair Hearing if internal review, negotiation, and or mediation with the MCO cannot resolve the appeal.

Scoring element G5.12 identifies the parties to the State Fair Hearing. One MCO did not satisfy the requirements for this scoring element as policies and procedures did not include a representative of a deceased member's estate as a party to the State Fair Hearing process.

Scoring element G5.13 requires MCOs to provide all relevant State Fair Hearing materials to the appropriate party, upon request, within five business days or sooner. Three MCOs did not satisfy the requirements for this scoring element as this requirement was not addressed in the MCOs' policies and procedures.

G6 Expedited resolution of appeals – 42 CFR 438.410

MCOs must establish and maintain an expedited review process for appeals, when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. If a request for an expedited resolution is denied, the MCO must transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the member prompt oral notice of the denial. The standard, G6, contains three scoring elements for each MCO, for a total of 42 scoring elements. The MCOs satisfied requirements for 41 out of 42 scoring elements, for a score of 97.6 percent, and a rating of Excellent.

Scoring element G6.2 requires MCOs to ensure that punitive action is not taken against anyone who requests an expedited resolution or supports a member's appeal. One MCO did not satisfy the requirements of this scoring element as policies and procedures only specified that punitive action is not taken against members if they request an expedited resolution to an appeal.

G7 Information about grievance systems to providers – 42 CFR 438.414

MCOs are required to provide information about the member grievance and appeal system to all providers at the time they enter into a contract with the organization. The standard, G7, contains one scoring element for each MCO, for a total of 14 scoring elements. The MCOs satisfied requirements for three out of 14 scoring elements, for a score of 21.4 percent, and a rating of Poor.

Scoring element G7.1 requires the MCO to give providers and subcontractors specific information about the MCO's member grievance and appeal system. The MCO is also required to provide a copy of both the *Wisconsin BadgerCare Plus or Medicaid SSI-HMO Ombuds Brochure* and the DHS *HMO and PIHP Member Grievances and Appeals Guide* to providers and subcontractors. The information must be provided at the time of contracting and within three weeks of receiving updated information from DHS. Eleven MCOs did not satisfy the requirements of this scoring element as policies and procedures did not demonstrate the MCOs had processes in place to provide the required documents to providers at the time of contracting or within the timeframe specified when updated information was received from DHS.

G8 Recordkeeping and reporting – 42 CFR 438.416

MCOs are required to maintain records of grievances and appeals and review the information as part of its ongoing monitoring procedures. The standard, G8, contains two scoring elements for each MCO, for a total of 28 scoring elements. The MCOs satisfied requirements for 25 out of 28 scoring elements, for a score of 89.3 percent, and a rating of Very Good.

Scoring element G8.2 details the required elements of each grievance and appeal record that is maintained by MCOs. Two MCOs did not satisfy the requirements of this scoring element as one MCO did not identify the data elements maintained for each grievance record, and one MCO did not detail the information maintained for each appeal or grievance record.

G9 Continuation of benefits – 42 CFR 438.420

MCOs are required to provide written notices to members, per DHS-MCO contract requirements, that inform them of the right to continue services while an appeal is pending, and that they could be held responsible to pay back the cost of these services if the appeal decision is not in the member's favor. The standard, G9, contains four scoring elements for each MCO, for a total of 56 scoring elements. The MCOs satisfied requirements for 52 out of 56 scoring elements, for a score of 92.9 percent, and a rating of Excellent.

Scoring element G9.1 identifies the criteria for determining timely filing for continuation of benefits. One MCO did not satisfy the requirements of this scoring element as information related to continuation of benefits was not specified within the MCO's policies and procedures.

Scoring element G9.3 specifies the criteria and timeframe related to continuation of benefits. Two MCOs did not satisfy the requirements of this scoring element as policies and procedures did not specify the conditions under which benefits would continue.

Scoring element G9.4 states if the final resolution of the appeal or State Fair Hearing is adverse to the member, the MCO may recover the cost of services continued. One MCO did not satisfy the requirements of this scoring element as information related to continuation of benefits or the recovery of the cost of services continued during the appeals process was not specified within the MCO's policies and procedures.

G10 Effectuation of reversed appeal decisions – 42 CFR 438.424

If the MCO or State Fair Hearing officer reverses a decision about services not furnished during the appeal, the MCO must authorize and provide the services as expeditiously as the member's condition requires. In addition, if the member received the services while the appeal was pending and the appeal is ruled in favor of the member, the MCO must pay for those services. The standard, G10, contains two scoring elements for each MCO, for a total of 28 scoring elements. The MCOs satisfied requirements for 22 out of 28 scoring elements, for a score of 78.6 percent, and a rating of Good.

Scoring element G10.1 specifies if the MCO appeal process or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date the MCO receives notice reversing the determination. Three MCOs did not satisfy the requirements of this

scoring element as this requirement was not addressed in grievances and appeals policies and procedures.

Scoring element G10.2 states that if the MCO appeal process or State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services during the appeal, the MCO must pay for those services. Three MCOs did not satisfy the requirements of this scoring element as this requirement was not addressed in grievances and appeals policies and procedures.

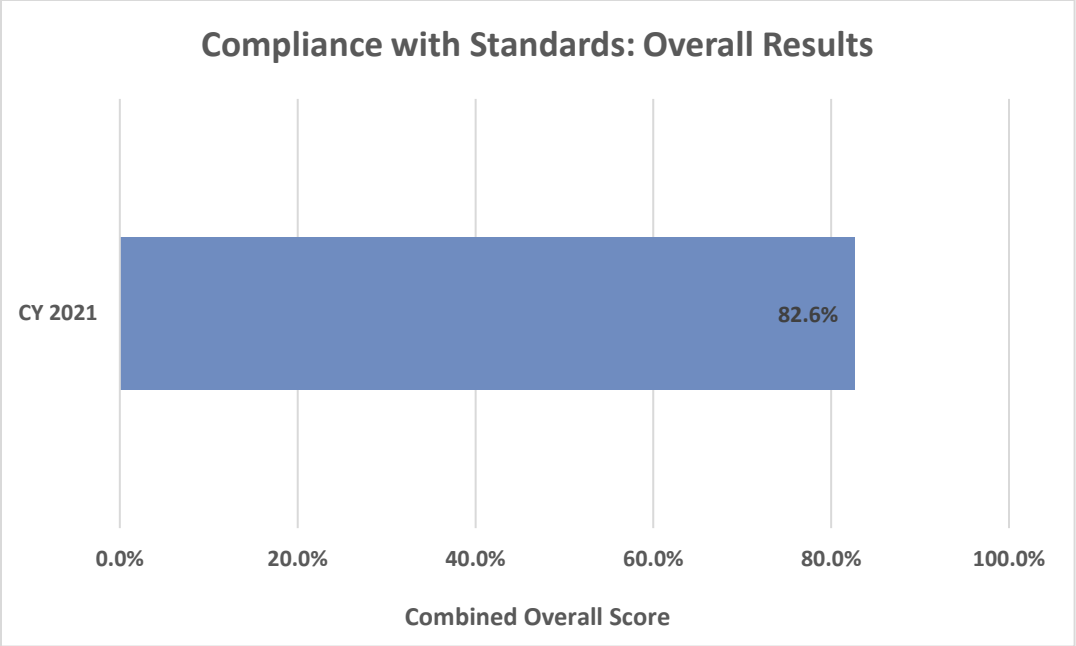
Overall Results by PIHP

MetaStar conducted two compliance with standards reviews during CY 2021 for PIHPs that are not accredited by NCQA. The following tables and graphs indicate the PIHPs' overall level of compliance in the CY 2021 Compliance with Standards review.

For both PIHPs, the statewide overall compliance score is 82.6 percent, and a rating of Very Good. The table below indicates the overall level of compliance with each one of the focus areas of standards comprising the Compliance with Standards review in this reporting period.

PIHP Compliance with Standards Review CY 2021			
Focus Area	**Scoring Elements**	**Percentage**	**Rating**
MCO Standards	146/157	93.0%	EXCELLENT
QAPI	26/32	81.3%	VERY GOOD
Grievance Systems	60/92	65.2%	FAIR
Overall	**232/281**	**82.6%**	**VERY GOOD**

The graph on the following page illustrates the PIHPs' overall compliance with these standards.



Each section that follows provides a brief explanation of a compliance with standards focus area, including rationale for any areas the PIHPs were not fully compliant, followed by a table and bar graph. Additionally, Appendix 3 includes results for each standard by PIHP.

Results for Compliance with Standards Review Focus Area - MCO Standards

PIHP'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.

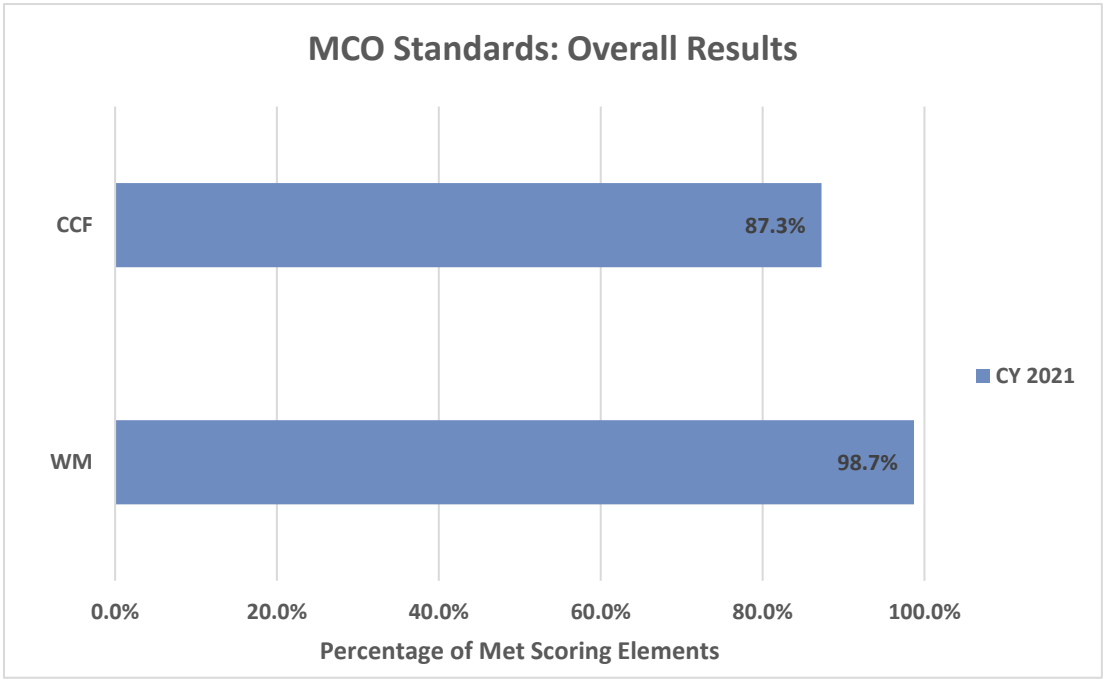
PIHPs are also responsible to help members understand their rights as well as to ensure those rights are protected. This requires an adequate organizational structure and sound processes that adhere to federal and state requirements and are capable of ensuring that members' rights are protected.

For both PIHPs, the statewide MCO Standards compliance score is 93 percent, and a rating of Excellent. The following table indicates the overall level of compliance with the MCO Standards in this calendar year.

MCO Standards: Provider Network, Care Management, and Enrollee Rights			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M1	8/10	80.0%	VERY GOOD
M2	14/14	100.0%	EXCELLENT
M3	4/4	100.0%	EXCELLENT
M4	13/14	92.9%	EXCELLENT
M5	12/12	100.0%	EXCELLENT
M6	9/10	90.0%	EXCELLENT
M7	8/8	100.0%	EXCELLENT
M8	14/14	100.0%	EXCELLENT
M9	20/22	90.9%	EXCELLENT
M10	5/6	83.3%	VERY GOOD
M11	7/8	87.5%	VERY GOOD
M12	2/2	100.0%	EXCELLENT
M13	16/19	84.2%	VERY GOOD
M14	8/8	100.0%	EXCELLENT
M15	6/6	100.0%	EXCELLENT
M16*	NA	NA	NA
Overall	**146/157**	**93.0%**	**EXCELLENT**

* M16 is evaluated as part of the PIHPs' ISCA, conducted once every three years. The ISCA occurs separate from the Compliance with Standards review.

The graph below illustrates the PIHPs' overall compliance with these standards.



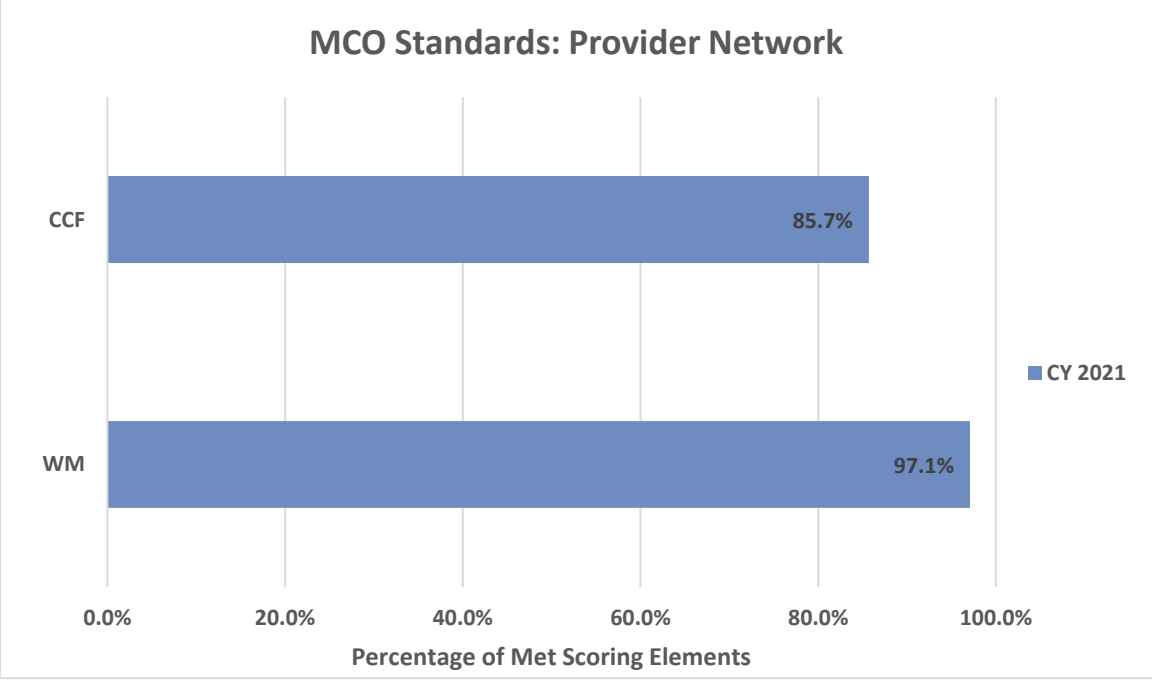
Observation and Analysis: MCO Standards, Provider Network

PIHPs must provide members timely access to high quality long-term care and health care services by developing and maintaining the structure, operations, and processes to ensure availability of accessible, culturally competent services through a network of qualified service providers. Six standards address requirements related to availability of services, provider selection, sub-contractual/provider relationships, and delegation.

For both PIHPs, the statewide MCO Standards, Provider Network compliance score is 91.3 percent, and a rating of Excellent. The table below indicates the overall level of compliance with the MCO Standards, Provider Network standards in this calendar year.

MCO Standards: Provider Network			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M1	8/10	80.0%	VERY GOOD
M2	14/14	100.0%	EXCELLENT
M3	4/4	100.0%	EXCELLENT
M4	13/14	92.9%	EXCELLENT
M13	16/19	84.2%	VERY GOOD
M14	8/8	100.0%	EXCELLENT
Overall	**63/69**	**91.3%**	**EXCELLENT**

The graph below illustrates each PIHP's overall compliance with this focus area.



M1 Availability of services - 42 CFR 438.206

The PIHP 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 PIHP**.** The standard, M1, contains five scoring elements for each PIHP, for a total of 10 scoring elements. The PIHPs satisfied requirements for eight out of 10 scoring elements, for a score of 80.0 percent, and a rating of Very Good.

All providers at each PIHP must be contracted as a network provider with a written agreement in place before serving members. Both PIHPs demonstrated robust provider networks and systems in place to ensure adequate access to services as well as electronic provider directories on the organization's websites.

Scoring element M1.3 requires the PIHP to have written policies and procedures to provide for a second opinion from a network provider or arrange for the member to obtain one outside the network, at no cost to the member. One PIHP did not meet this requirement, as it did not have a written policy or procedure in place to direct care coordination staff on the process to undertake when members or their family request a second opinion.

Scoring element M1.4 requires the PIHP to adequately and timely cover services with non-network providers if the PIHP's network is unable to provide the covered necessary services. One PIHP did not meet this requirement as its policies did not clearly state that an out-of-network provider will be covered at no extra cost to the member for as long as the PIHP's network is unable to provide a necessary and covered service.

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

To ensure timely access to care and services, the PIHP requires its providers to meet state standards. The PIHP must monitor compliance, and take corrective action if needed. The standard, M2, contains seven scoring elements for each PIHP, for a total of 14 scoring elements. The PIHPs satisfied requirements for 14 out of 14 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

Both PIHPs had mechanisms in place to ensure timely access to services, such as after-hours lines, regular reporting, and monitoring. Examples of monitoring included data collection through monthly utilization reviews and referral tracking, grievance reviews, provider concern monitoring, and internal meetings. One PIHP requires its providers to attest to reading, understanding, and implementing or abiding by information contained in policies and procedures on its website, and linked in the provider fee-for-service contract. Both PIHPs satisfied requirements for this standard.

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

The PIHP 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, contains two scoring elements for each PIHP, for a total of four scoring elements. The PIHPs satisfied requirements for four out of four scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The PIHPs demonstrated efforts to ensure cultural diversity in a variety of ways, including diversity trainings for organizational staff, translation of documents into different languages, coordination of interpreter services for members, incorporation of cultural preferences into assessments, and educational materials for providers. Both programs confirmed members have the right to request or change providers, as needed, to ensure their cultural, spiritual, health and healing practices, religious beliefs, and customs are addressed. Both PIHPs satisfied requirements for this standard.

M4 Network adequacy - 42 CFR 438.207

The PIHP must ensure its delivery network is sufficient to provide adequate access to all services. The standard, M4, contains seven scoring elements for each PIHP, for a total of 14 scoring elements. The PIHPs satisfied requirements for 13 out of 14 scoring elements, for a score of 92.9 percent, and a rating of Excellent.

Scoring element M4.1 requires the PIHP to use the anticipated enrollment as part of ensuring a sufficient provider network. One PIHP did not meet this requirement as the process described during the discussion session was not documented in the PIHP's policies or procedures.

M13 Provider selection - 42 CFR 438.214

The PIHP must have a written process for the selection and periodic evaluation of qualified providers. The PIHP is responsible for ensuring all applicable provider requirements are met at initial contracting and throughout the duration of the contract. The standard, M13, contains nine scoring elements for PIHPs that do not delegate selection of providers to another entity, and 10 scoring elements for PIHPs that delegate this function, for a total of 19 scoring elements. The PIHPs satisfied requirements for 16 out of 19 scoring elements, for a score of 84.2 percent, and a rating of Very Good.

Scoring element M13.4 prohibits the PIHP from discriminating against providers who serve high-risk populations or specialize in conditions that require higher-cost treatments. One PIHP did not meet this requirement. Although staff reported providers were not excluded from the network due to serving members that require higher cost treatment, the PIHP's provider selection documents did not include this assurance regarding non-discrimination.

Scoring element M13.5 requires that the PIHP retain the right to approve, suspend, or terminate any provider when the provider selection process is delegated to another entity. One PIHP did not meet this requirement as its subcontract with a delegated entity did not identify that the PIHP retained this right, only that it reserved the right to request replacement of personnel.

Scoring element M13.7 states the PIHP must immediately forward the names of both institutional and individual providers terminated from the provider network for quality concerns to DHS. The information also must be reported to other entities as required by law. One PIHP did not meet this requirement as the timeframe related to reporting providers to DHS reflected a seven-day notification versus immediate notification.

M14 Subcontractual relationships and delegation - 42 CFR 438.230

The PIHP must oversee and be accountable for functions and responsibilities that it delegates to any subcontractor/provider. The PIHP must monitor the subcontractor/provider's performance, and take corrective action if needed. The standard, M14, contains four scoring elements for each PIHP, for a total of eight scoring elements. The PIHPs satisfied requirements for eight out of eight scoring elements, for a score of 100.0 percent, and a rating of Excellent.

Both PIHPs subcontract with agencies for the provision of care coordination services. Prior to executing a contract for this delegated activity, interested agencies were required to submit a response to the PIHP's request for proposal (RFP). The respective RFPs defined the criteria used to evaluate the proposals, and contracts were awarded to the entities presenting the best combination of quality of service, price, delivery, compliance to specifications, and capacity to perform the identified service. The PIHPs monitor each subcontracted entity on a regular basis throughout the calendar year and impose corrective action as necessary. Both PIHPs satisfied requirements for this standard.

Observation and Analysis: MCO Standards, Care Management

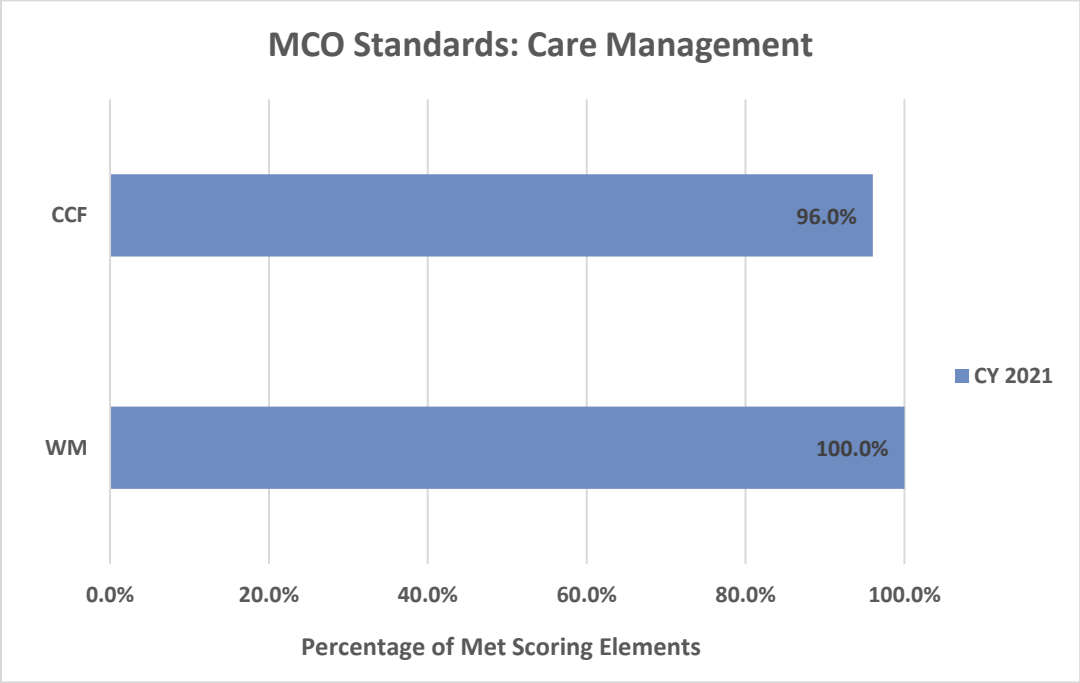
PIHPs must provide members timely access to high quality long-term care and health care services by developing and maintaining the structure, operations, and processes to ensure coordination and continuity of member care, timely authorization of services, and issuance of notices to members. Five standards address requirements related to coordination and continuity of care, and coverage and authorization of services.

For both PIHPs, the statewide MCO Standards, Care Management compliance score is 98 percent, and a rating of Excellent. The table on the following page indicates the overall level of compliance with the MCO Standards, Care Management standards in this calendar year.

MCO Standards: Care Management			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M5	12/12	100.0%	EXCELLENT
M6	9/10	90.0%	EXCELLENT
M7	8/8	100.0%	EXCELLENT
M8	14/14	100.0%	EXCELLENT
M15	6/6	100.0%	EXCELLENT
M16*	NA	NA	NA
Overall	**49/50**	**98.0%**	**EXCELLENT**

* M16 is evaluated as part of the PIHP's ISCA, conducted once every three years. The ISCA occurs separate from the Compliance with Standards review.

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



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 PIHPs must implement procedures to deliver care to and coordinate services for all PIHP members (M5). The standard, M5, contains six scoring elements for each PIHP, for a total of 12 scoring elements. The PIHPs satisfied requirements for 12 out of 12 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

Both PIHPs had policies and procedures in place that demonstrated a strengths-based and team-oriented approach to care management. The intake processes prevent duplication of services through the coordination and communication with other organizations and community partners serving members. PIHP staff receive comprehensive confidentiality training upon hire and annually thereafter to protect and maintain the confidentiality of member information. Both PIHPs satisfied requirements for this standard.

PIHPs must implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State and identified to the PIHP 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, contains five scoring elements for each PIHP, for a total of 10 scoring elements. The PIHPs satisfied requirements for nine out of 10 scoring elements, for a score of 90.0 percent, and a rating of Excellent.

Scoring element M6.2 includes a requirement that the PIHP must treat a request for change in the child and family team membership as a grievance, following the notification and timeframe requirements detailed in the DHS *Member Grievance and Appeals Guide*. The family must have the ability to request a change in team composition without reproach, with the related language included in the PIHP's handbook. One PIHP did not meet the requirement related to this scoring element as the information shared in the family handbook did not include the required language.

M7 Disenrollment: requirements and limitations - 42 CFR 438.56

PIHPs must comply with requirements for member disenrollment. The standard, M7, contains four scoring elements for each PIHP, for a total of eight scoring elements. The PIHPs satisfied requirements for eight out of eight scoring elements, for a score of 100.0 percent, and a rating of Excellent.

Enrollment in the PIHP is voluntary, and typically a member is enrolled for an average of 18 months or less. The plan for disenrollment begins at the time of enrollment to ensure appropriate supports and services are in place after enrollment ends. Reasons for disenrollment include successful program completion, corrections placement, move outside of the service area, or aging out of the program, among others. Both PIHPs satisfied requirements for this standard.

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

PIHPs' policies and procedures for service authorizations must comply with required standards. The standard, M8, contains seven scoring elements for each PIHP, for a total of 14 scoring elements. The PIHPs satisfied requirements for 14 out of 14 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

PIHP policies and procedures related to service authorization decision making have been implemented that comply with DHS contract requirements related to timeframes and extensions if additional time is needed. Both PIHPs satisfied requirements for this standard.

M15 Practice guidelines - 42 CFR 438.236

PIHPs are required to adopt, apply, and disseminate practice guidelines based on the needs of its members. The standard, M15, contains three scoring elements for each MCO, for a total of six scoring elements. The MCOs satisfied requirements for six out of six scoring elements, for a score of 100.0 percent, and a rating of Excellent.

Each PIHP uses a combination of internally developed and external clinical practice guidelines for prevention and wellness services for members. Practice guidelines are disseminated upon request and are available on each PIHPs' website for staff, providers, and members to download as needed. Both PIHPs satisfied requirements for this standard.

M16 Health information systems – 42 CFR 438.242

PIHPs 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 PIHPs' ISCA, conducted once every three years. The ISCA occurs separate from the Compliance with Standards review.

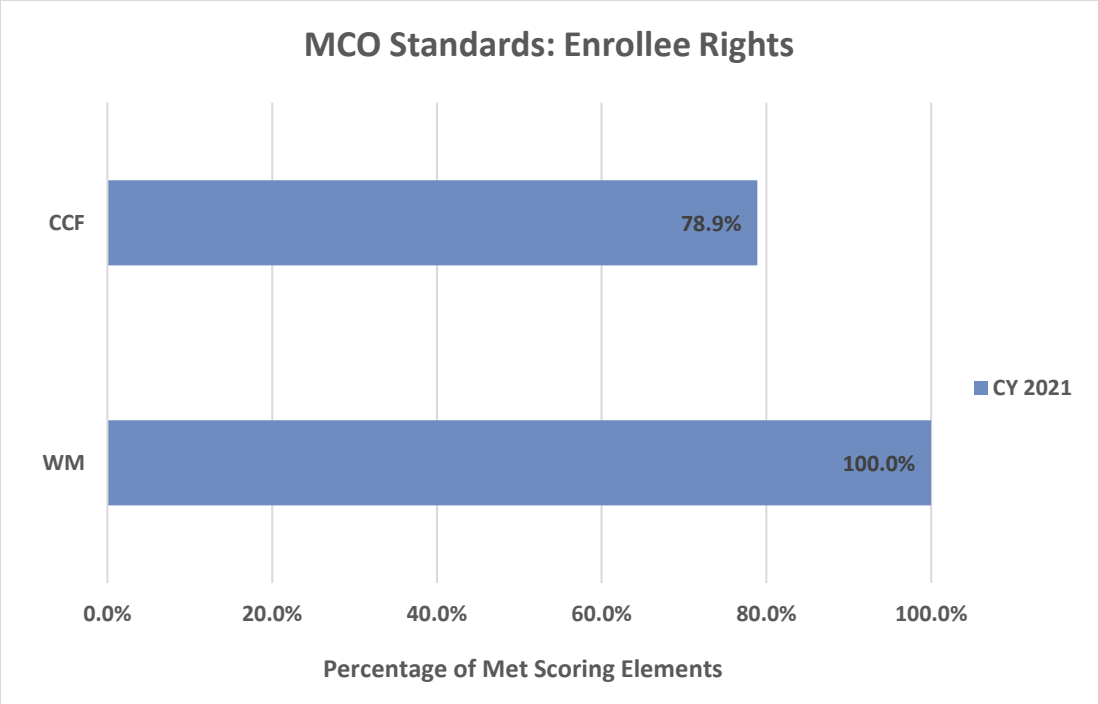
OBSERVATION AND ANALYSIS: MCO STANDARDS, ENROLLEE RIGHTS

PIHPs are responsible to help members understand their rights as well as to ensure those rights are protected. This requires an adequate organizational structure and sound processes that adhere to 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.

For both PIHPs, the statewide MCO Standards, Enrollee Rights compliance score is 89.5 percent, and a rating of Very Good. The table below indicates the overall level of compliance with the MCO Standards, Enrollee Rights standards in this calendar year.

MCO Standards: Enrollee Rights			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M9	20/22	90.9%	EXCELLENT
M10	5/6	83.3%	VERY GOOD
M11	7/8	87.5%	VERY GOOD
M12	2/2	100.0%	EXCELLENT
Overall	**34/38**	**89.5%**	**VERY GOOD**

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



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

Organizations are required to provide readily accessible written information to members in a manner and format that is easily understood. The standard, M9, contains 11 scoring elements for each PIHP, for a total of 22 scoring elements. The PIHPs satisfied requirements for 20 out of 22 scoring elements, for a score of 90.9 percent, and a rating of Excellent.

Scoring element M9.1 requires the PIHP inform its members that electronic information is available in paper format upon request, without charge, and must be provided within five business days. One PIHP did not satisfy the requirements of this scoring standard as its policies, website, and enrollment materials did not include the required information.

Scoring element M9.3 states the PIHP must provide a member handbook within 10 days after receiving notice of the member's enrollment. One PIHP did not satisfy the requirements of this scoring standard as policies and procedures did not identify the timeframe to provide the handbook to new members, and staff were not able to confirm that the handbook is consistently distributed within the required timeframe.

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, PIHPs will not restrict a provider acting within the lawful scope of practice, or from advising or advocating on behalf of a member. The standard, M10, contains three scoring elements for each PIHP, for a total of six scoring elements. The PIHPs satisfied requirements for five out of six scoring elements, for a score of 83.3 percent, and a rating of Very Good.

Scoring element M10.2 identifies that a PIHP may not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is their patient. One PIHP did not satisfy the requirements for this scoring element as its policies and procedures did not include this information.

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)

PIHPs are required to have written policies and procedures for member rights and advance directives, which include the right to participate in decisions regarding his or her care, the right to refuse treatment, and the right to be free from any form of restraint. The standard, M11, contains four scoring elements for each PIHP, for a total of eight scoring elements. The PIHPs satisfied requirements for seven out of eight scoring elements, for a score of 87.5 percent, and a rating of Very Good.

Scoring element M11.4 requires PIHPs to provide written information regarding advance directives to members age 18 or older. The written information must be updated to reflect any changes in State law as soon as possible, but not later than 90 days from the effective date of change. One PIHP did not satisfy the requirement for this scoring element as its advance directives policy did not include the requirement to assure updates will occur within the required timeframe.

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

The PIHP must comply with all applicable Federal and State laws for the protection of member rights. The standard, M12, contains one scoring element for each PIHP, for a total of two scoring elements. The PIHPs satisfied requirements for two out of two scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The member rights policies implemented by each PIHP outlined the organization's commitment to ensuring each member and family is aware of their rights and responsibilities in the treatment process, and that their rights are to be honored and respected. Additional policies and procedures demonstrated dignity and respect in all interactions with members. Both PIHPs satisfied requirements for this standard.

Results for Compliance with Standards Review Focus Area – Quality Assessment and Performance Improvement

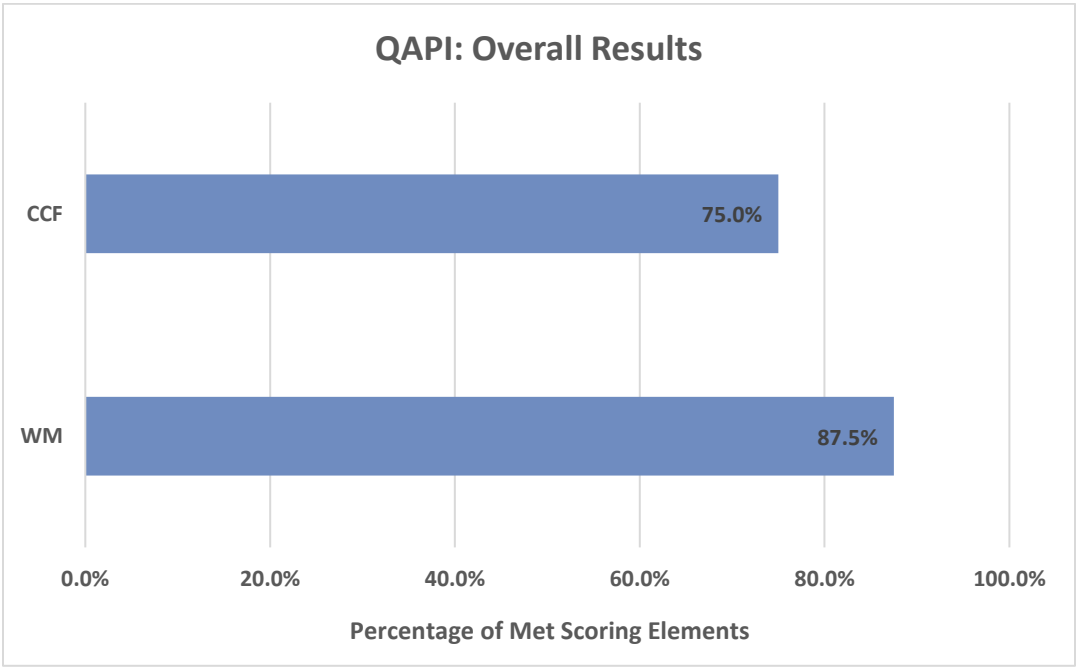
PIHPs must provide members timely access to high quality health care services by developing and maintaining the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement.

For all PIHPs, the statewide QAPI compliance score is 81.3 percent, and a rating of Very Good. The following table indicates the overall level of compliance with the QAPI standards in this calendar year.

Quality Assessment and Performance Improvement			
Standard	**Scoring Elements**	**Percentage**	**Rating**
Q1	14/18	77.8%	GOOD
Q2	12/12	100.0%	EXCELLENT
Q3*	NA	NA	NA
Q4*	NA	NA	NA
Q5	0/2	0.0%	POOR
Overall	**26/32**	**81.3%**	**VERY GOOD**

*Q3 is evaluated as part of the PIHPs' Validation of Performance Measures activity, which is conducted on a different cycle than the Compliance with Standards Review. *Q4 is evaluated as part of the PIHPs' Validation of Performance Improvement Projects activity, which is conducted on a different cycle than the Compliance with Standards Review.

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



OBSERVATION AND ANALYSIS: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Q1 Quality assessment program – 42 CFR 438.330(a)

PIHPs must establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members. The QAPI program must meet minimum requirements outlined in the DHS-PIHP contract related to its administrative structures, stakeholder participation, quality work plan, and monitoring activities. The standard, Q1, contains nine scoring elements for each PIHP, for a total of 18 scoring elements. The PIHPs satisfied requirements for 14 out of 18 scoring elements, for a score of 77.8 percent, and a rating of Good.

Scoring element Q1.1 requires the PIHP's governing body to ratify the annual QAPI work plan. Scoring element Q1.2 further requires the PIHP's governing body to approve the QAPI program and plan, conduct a formal annual review, and direct any modifications needed. Scoring element Q1.8 requires the PIHP to designate a senior executive as the person responsible for the operation and success of its QAPI program. One PIHP did not satisfy the requirements of these scoring elements. One PIHP delegated the QAPI activities to a subcontractor; however, the PIHP's governing body did not provide input or give approval of the plan, and the documentation submitted did not designate a senior executive responsible for the QAPI program.

The DHS-PIHP contract includes requirements regarding member, staff, and provider participation in the quality program. Scoring element Q1.3 requires at least 50 percent of the interdisciplinary quality committee to be parents of current or previous members. One PIHP did not satisfy the requirements of this scoring element as they described difficulty in recruiting additional family representatives, and only two of eleven identified committee members were parents of current or previous members.

Q2 Quality assessment work plan – 42 CFR 438.330(b)

The comprehensive quality assessment and performance improvement program must, at a minimum, include mechanisms to detect underutilization and overutilization of services, assess the quality and appropriateness of care furnished to members, collect and submit performance improvement data, conduct performance improvement projects, and monitor and evaluate provider performance. The quality plan should outline the scope of activities, goals, objectives, timelines, responsible persons, and be based on findings from quality improvement efforts. The standard, Q2, contains six scoring elements for each MCO, for a total of 12 scoring elements. The MCOs satisfied requirements for 12 out of 12 scoring elements, for a score of 100 percent, and a rating of Excellent.

Both PIHPs submitted quality work plans with defined performance measures, sources of data, and frequency of monitoring efforts. Quality committees met at least quarterly throughout the

calendar year to review progress toward the identified quality initiatives. Both PIHPs satisfied requirements for this standard.

Q3 Performance measurement – 42 CFR 438.330(c)

PIHPs must measure and report performance data on standard measures required by the DHS-PIHP contract. This standard is evaluated as part of the PIHPs' Validation of Performance Measures review, which is conducted and reported on a different cycle than the Compliance with Standards review.

Q4 Performance improvement – 42 CFR 438.330(d)

PIHPs must conduct performance improvement projects designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. This standard is evaluated as part of the PIHPs' Validation of Performance Improvement Project review, which is conducted and reported on a different cycle than the Compliance with Standards review.

Q5 Evaluation of the quality assessment program and work plan – 42 CFR 438.330(e)(2)

PIHPs must develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program, and determine whether the program has achieved improvement in the quality of service provided to members. The standard, Q5, contains one scoring element for each PIHP, for a total of two scoring elements. The PIHPs satisfied requirements for zero out of two scoring elements, for a score of 0.0 percent, and a rating of Poor.

Scoring element Q5.1 requires PIHPs to evaluate the overall effectiveness of its QAPI program annually. Neither PIHP satisfied the requirements related to this scoring element. One PIHP did not submit documents related to this scoring element and confirmed it did not have a written evaluation of the quality program. The other PIHP identified its decision to incorporate the written evaluation of the quality work plan into the organization's year-end report. However, the year-end report did not identify or summarize the findings related to several of the performance indicators identified in the work plan, and the overall effectiveness of the entire quality program and goals were not fully described in the year-end report.

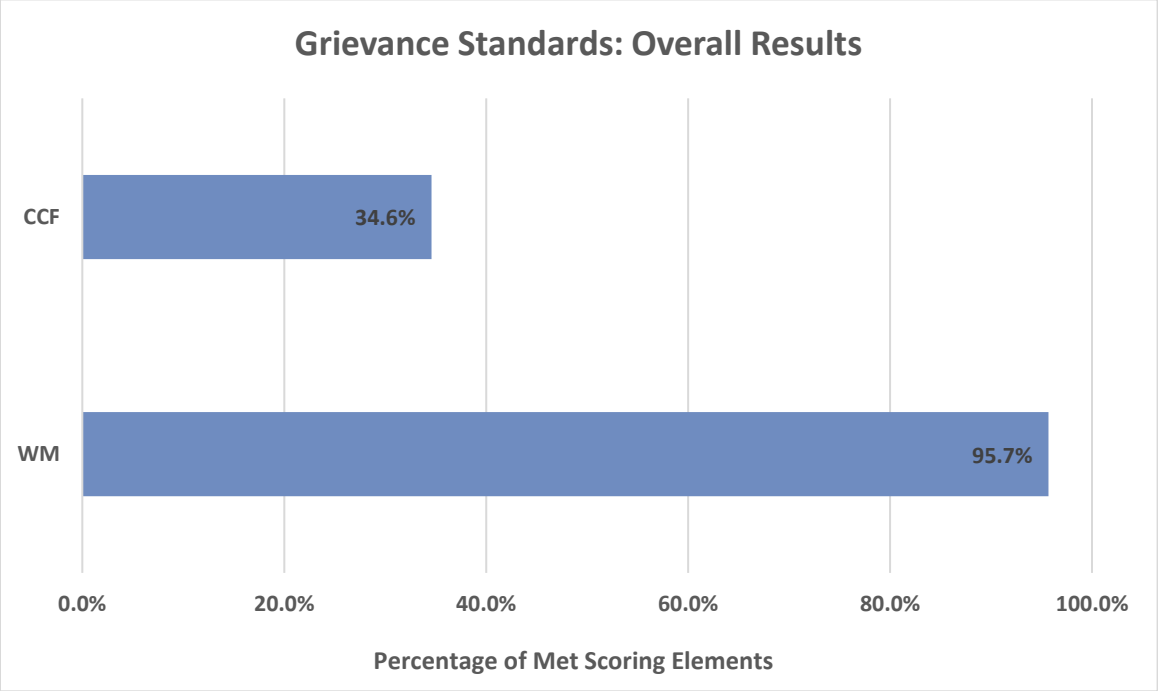
Results for Compliance with Standards Focus Area – Grievance Systems

PIHPs must maintain an effective system for members to exercise their rights related to grievances and appeals.

For all PIHPs, the statewide Grievance Systems compliance score is 65.2 percent, and a rating of Fair. The table on the following page indicates the overall level of compliance with the Grievance System standards in this calendar year.

Grievance Systems			
Standard	**Scoring Elements**	**Percentage**	**Rating**
G1	7/10	70.0%	GOOD
G2	10/14	71.4%	GOOD
G3	8/14	57.1%	POOR
G4	2/4	50.0%	POOR
G5	17/26	65.4%	FAIR
G6	5/6	83.3%	VERY GOOD
G7	1/2	50.0%	POOR
G8	3/4	75.0%	GOOD
G9	5/8	62.5%	FAIR
G10	2/4	50.0%	POOR
Overall	**60/92**	**65.2%**	**FAIR**

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



Observation and Analysis: Grievance Systems

G1 and G2 Grievance systems general requirements – 42 CFR 438.228, 42 CFR 438.402

PIHPs must have a grievance and appeal system in place that includes an internal grievance process, an appeal process, and access to the state's Fair Hearing system (G1). The standard, G1, contains five scoring elements for each MCO, for a total of 10 scoring elements. The MCOs satisfied requirements for seven out of 10 scoring elements, for a score of 70.0 percent, and a rating of Good.

Scoring element G1.1 requires the PIHP to ensure members have the option to grieve or appeal any negative response to the PIHP's Board of Directors. The Board of Directors may delegate the authority to the PIHPs grievance and appeal committee, but the delegation must be in writing. One PIHP did not satisfy the requirements related to this scoring element as its grievance and appeal policy and related documents did not inform members how to submit a grievance or appeal to the PIHP's Board of Directors, and the Board of Directors have not formally delegated the responsibility of processing grievances and appeals to the PIHP grievance and appeal committee.

Scoring element G1.3 requires the PIHP to identify a contact person within the organization who is responsible for receiving, routing, and processing grievances and appeals. One PIHP did not satisfy the requirements related to this scoring element as a contact person was noted to receive and process grievances, but did not address the requirement related to a contact person to receive and process appeals.

Scoring element G1.5 states the PIHP's advocate must attempt to resolve issues or concerns through internal review, negotiation, or medication, if possible, when a member presents a grievance or appeal. One PIHP did not satisfy the requirements of this scoring element as documentation did not outline the role of the PIHP advocate related to the grievance and appeal resolution process.

PIHPs must accept grievances and appeals from members and their preferred representatives, including providers, with the member's written consent. PIHPs must follow the state-specified timeframes associated with standard appeals. Additionally, members or member's legal decision makers, or anyone acting on the member's behalf with the member's permission, may file a grievance or appeal orally or in writing (G2). The standard, G2, contains seven scoring elements for each PIHP, for a total of 14 scoring elements. The PIHPs satisfied requirements for 10 out of 14 scoring elements, for a score of 71.4 percent, and a rating of Good.

Scoring element G2.1 requires the PIHP to only have one level of appeal for members. One PIHP did not satisfy the requirements related to this scoring element as documentation did not clearly state the organization only has one level of appeals.

Scoring element G2.2 states a member must exhaust the PIHP's appeals process before requesting a State Fair Hearing. However, if the PIHP fails to adhere to the notice and timing requirements, the member is deemed to have exhausted the process and may request a State Fair Hearing. One PIHP did not satisfy the requirements related to this scoring element as member documentation did not include the information about exhausting appeals if the organization did not adhere to notice and timing requirements.

Scoring element G2.3 identifies that a provider or an authorized representative may request an appeal, file a grievance with the PIHP, or request a State Fair Hearing on behalf of the member, if there is documented consent from the member. One PIHP did not satisfy the requirements related to this scoring element as the organization did not identify that providers may request an appeal, file a grievance with the PIHP, or request a State Fair Hearing on behalf of the member with documented consent from the member.

Scoring element G2.6 states a member may file a grievance orally or in writing. One PIHP did not satisfy the requirements related to this scoring element as documentation stated that oral grievances must be confirmed in writing.

G3 Notice to members – 42 CFR 438.404

Notices to members must be in writing and meet language and format requirements to ensure ease of understanding for members. The notices must be delivered to the member in the timeframes associated with each type of adverse decision. Additionally, if the PIHP extends the timeframe for the decision-making process, the member must receive a written notice of the reason for extension and inform the member of the right to grieve the extension. The standard, G3, contains seven scoring elements for each MCO, for a total of 14 scoring elements. The MCOs satisfied requirements for eight out of 14 scoring elements, for a score of 57.1 percent, and a rating of Poor.

Scoring element G3.2 specifies when a notice of adverse benefit determination must be issued. Neither PIHP satisfied the requirements related to this scoring element. Both PIHPs identified their understanding that a notice of adverse benefit determination only needs to be issued if the PIHP is making a decision without member agreement. The rationale provided was that the PIHPs strive to make decisions with the member and family during team meetings, and as consensus is reached during that meeting, notices are not issued. However, the DHS-PIHP contract clearly specifies the requirement to issue a notice for any termination, suspension, or reduction of a previously authorized and covered service, regardless of member agreement with the decision.

Scoring element G3.3 requires a PIHP to mail a notice of adverse benefit determination for denial of payment at the time of any action affecting the claim. One PIHP did not satisfy the requirements related to this scoring element as the PIHP's policies and procedures did not reflect this requirement.

Scoring element G3.5 states the PIHP must give its members written notice of a decision to extend the timeframe for standard service authorization, including the member's right to file a grievance. One PIHP did not satisfy the requirements related to this scoring element as its policies and procedures did not include instructions to staff to ensure written notices are issued as required related to decision-making timeframe extensions.

Scoring element G3.6 requires a notice of adverse benefit determination to be issued if a service authorization decision is not reached within the specified timeframe. The notice must be mailed no later than the date the timeframe expires. One PIHP did not satisfy the requirements related to this scoring element as its policies and procedures did not include instructions to staff to ensure written notices are issued as required when service authorization decisions are not reached within the specified timeframe.

Scoring element G3.7 states an expedited service authorization must be made within 72 hours, but the timeframe can be extended up to 14 calendar days. One PIHP did not satisfy the requirements related to this scoring element as the organization's policy and procedure did not identify when the expedited decision-making timeframe can be extended or under what conditions the timeframe can be extended.

G4 Handling of grievances and appeals – 42 CFR 438.406

PIHPs must give members any reasonable assistance in completing forms and taking other procedural steps in the grievance and appeal process. The PIHP process must ensure individuals who make decisions on the grievance and appeal committee, have not been involved in any previous level of review or decision-making related to the issue. The committee must also include appropriate health care professionals. PIHPs are required to provide written confirmation of grievances and appeals; the opportunity for members to present evidence and allegation of fact or law, in person or in writing; and provide members the opportunity to examine their records. The standard, G4, contains two scoring elements for each PIHP, for a total of four scoring elements. The PIHPs satisfied requirements for two out of four scoring elements, for a score of 50.0 percent, and a rating of Poor.

Scoring element G4.1 requires the PIHP to give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. One PIHP did not satisfy the requirements related to this scoring element as documentation directed members to external resources for assistance related to a grievance or appeal, rather than noting the PIHP would provide any reasonable assistance.

Scoring element G4.2 requires the PIHP's grievance and appeal process to meet specific requirements, including ensuring members have a reasonable opportunity to present evidence and testimony. One PIHP did not satisfy the requirements related to this scoring element as documentation stated members can bring new evidence and witnesses to the grievance and appeal committee; the requirement does not limit a member to only new evidence and witnesses. In addition, the PIHP's grievance and appeal policy did not identify their grievance and appeal committee is responsible for processing all appeals or only those that require managers to be excluded from the process.

G5 Resolution and notification – 42 CFR 438.408

PIHPs are required to have a system in place to dispose of grievances and appeals as expeditiously as the member's situation and health condition requires, within standard and expedited timeframes established in the DHS-PIHP contract. The PIHP or member may extend the timeframes for resolution of grievances and appeals. If the PIHP requests the extension, it must provide the member with written notice of the reasons for the delay. Notice of resolution to members must be in writing and meet language and format requirements to ensure ease of understanding for members. The standard, G5, contains 13 scoring elements for each PIHP, for a total of 26 scoring elements. The PIHPs satisfied requirements for 17 out of 26 scoring elements, for a score of 65.4 percent, and a rating of Fair.

Scoring elements G5.2 and G5.3 detail the requirements for standard and expedited resolution of appeals. Scoring element G5.2 requires the PIHP to provide an initial response within 10 business days and a final response within 30 calendar days of receiving an appeal. Scoring element G5.3 requires expedited resolution of appeals within 72 hours of receiving the request for expedited resolution. One PIHP did not satisfy the requirements related to these scoring elements as the PIHP did not include the required timelines for standard resolution of appeals.

Scoring element G5.4 states the total timeline for the PIHP to finalize a formal grievance or appeal may not exceed 45 days from the date it is received. One PIHP did not satisfy the requirements related to this scoring element as documentation only detailed the timeframe for the resolution of grievances, and did not address the timeframe for the resolution of appeals.

Scoring element G5.5 requires the PIHP to meet specific requirements if extending the timeframe for a grievance or appeal. The PIHP must attempt to provide the member prompt oral notice, provide written notice within two calendar days, inform the member a grievance may be filed if the member disagrees with the extension decision, and resolve the appeal as expeditiously as the member's health condition requires. One PIHP did not satisfy the requirements related to this scoring element as the PIHP's grievances and appeals policy did not include all required elements for when the PIHP determines an extension is needed to resolve an appeal.

Scoring element G5.6 states if the PIHP fails to adhere to the notice and timing requirements, the member is deemed to have exhausted the PIHP's appeals process and may initiate a State Fair Hearing. One PIHP did not satisfy the requirements related to this scoring element as this information was not detailed in the PIHP's grievances and appeals policy.

Scoring element G5.10 states a member may request a State Fair Hearing only after receiving notice the PIHP is upholding the adverse benefit determination. One PIHP did not satisfy the requirements related to this scoring element as this information was not detailed in the PIHP's grievances and appeals policy.

Scoring element G5.11 indicates a member has 90 days from the date of the PIHP's notice of resolution to request a State Fair Hearing. One PIHP did not satisfy the requirements related to this scoring element as the PIHP's grievances and appeals policy identified the incorrect timeframe related to requesting a State Fair Hearing.

Scoring element G5.12 identifies the parties to the State Fair Hearing include the PIHP, the member, the member's representative, or the representative of a deceased member's estate. One PIHP did not satisfy the requirements related to this scoring element as the PIHP's grievances and appeals policy did not include the representative of a deceased member's estate as a party to the State Fair Hearing.

Scoring element G5.13 requires the PIHP to provide all relevant materials to the appropriate party within five business days of receiving a request for information regarding a State Fair Hearing. One PIHP did not satisfy the requirements related to this scoring element as the PIHP's grievances and appeals policy did not include the timeframe to submit documentation nor the specific documentation to submit as required.

G6 Expedited resolution of appeals – 42 CFR 438.410

PIHPs must establish and maintain an expedited review process for appeals, when the PIHP determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The PIHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. If a request for an expedited resolution is denied, the PIHP must transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the member prompt oral notice of the denial. The standard, G6, contains three scoring elements for each PIHP, for a total of six scoring elements. The PIHPs satisfied requirements for five out of six scoring elements, for a score of 83.3 percent, and a rating of Very Good.

Scoring element G6.2 identifies that the PIHP ensures punitive action is not taken against anyone, including a provider, who supports a member's appeal or requests an expedited resolution. One PIHP did not satisfy the requirements related to this scoring element as the PIHP's grievances and appeals policy did not include language confirming punitive action will not be taken against anyone who supports the member's appeal or requests an expedited resolution.

G7 Information about grievance systems to providers – 42 CFR 438.414

PIHPs are required to provide information about the member grievance and appeal system to all providers at the time they enter into a contract with the organization. The standard, G7, contains one scoring element for each PIHP, for a total of two scoring elements. The PIHPs satisfied

requirements for one out of two scoring elements, for a score of 50.0 percent, and a rating of Poor.

Scoring element G7.1 requires the PIHP to provide specific information about the PIHP's member grievance and appeal system to all providers and subcontractors at the time they enter into a contract, including the informational flyer on member grievance and appeal rights and the DHS *HMO and PIHP Member Grievance and Appeal Guide 3.0*. One PIHP did not satisfy the requirements related to this scoring element as the PIHP's website and submitted documents did not include providing these documents to all contracted providers.

G8 Recordkeeping and reporting – 42 CFR 438.416

PIHPs are required to maintain records of grievances and appeals and review the information as part of its ongoing monitoring procedures. The standard, G8, contains two scoring elements for each PIHP, for a total of four scoring elements. The PIHPs satisfied requirements for three out of four scoring elements, for a score of 75.0 percent, and a rating of Good.

Scoring element G8.2 requires the PIHP to maintain a record of each grievance or appeal that contains DHS-PIHP required information, including the member's name, general description, date received, date of review, resolution at each level of the appeal, and the date of the resolution at each level. One PIHP did not satisfy the requirements related to this scoring element as the record of all grievance decisions did not include the member's name.

G9 Continuation of benefits – 42 CFR 438.420

PIHPs are required to provide written notices to members, per DHS-PIHP contract requirements, that inform them of the right to continue services while an appeal is pending, and that they could be held responsible to pay back the cost of these services if the appeal decision is not in the member's favor. The standard, G9, contains four scoring elements for each PIHP, for a total of eight scoring elements. The PIHPs satisfied requirements for five out of eight scoring elements, for a score of 62.5 percent, and a rating of Fair.

Scoring element G9.1 states a member must file for continuation of benefits within 10 calendar days. One PIHP did not satisfy the requirements related to this scoring element as this information was not detailed in the PIHP's grievances and appeals policy.

Scoring element G9.2 outlines the conditions for continuation of benefits. One PIHP did not satisfy the requirements related to this scoring element as the PIHP's grievances and appeals policy did not identify the conditions that must be met for benefits to continue during an appeal.

Scoring element G9.3 requires the PIHP to continue benefits while the State Fair Hearing is pending unless the member fails to request the State Fair Hearing and continuation of benefits within 10 calendar days after the PIHP upholds the original adverse benefit determination. One

PIHP did not satisfy the requirements related to this scoring element as member information and the PIHP's grievances and appeals policy did not include that services could be discontinued if a member does not file for a State Fair Hearing within the required timeframes.

G10 Effectuation of reversed appeal decisions – 42 CFR 438.424

If the PIHP or State Fair Hearing officer reverses a decision about services not furnished during the appeal, the PIHP must authorize and provide the services as expeditiously as the member's condition requires. In addition, if the member received the services while the appeal was pending and the appeal is ruled in favor of the member, the PIHP must pay for those services. The standard, G10, contains two scoring elements for each PIHP, for a total of four scoring elements. The PIHPs satisfied requirements for two out of four scoring elements, for a score of 50.0 percent, and a rating of Poor.

Scoring element G10.1 requires the PIHP to authorize or provide disputed services that were not furnished while the State Fair Hearing appeal decision was pending, within 72 hours of the date the hearing decision reversed the PIHP's initial denial, limitation, or delay of services. One PIHP did not satisfy the requirements related to this scoring element as the PIHP's grievances and appeals policy did not address the reinstatement of benefits when applicable.

Scoring element G10.2 requires the PIHP to pay for services provided during an appeal when the decision was adverse to the PIHP. One PIHP did not satisfy the requirements related to this scoring element as this information was not detailed in the PIHP's grievances and appeals policy.

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 – SSI Care Management Review

Care Management Review (CMR) is an optional activity, *CMS External Quality Review (EQR) Protocols, Protocol 9: Conducting Focus Studies of Health Care Quality* assesses the access, quality, and appropriateness of care provided to members.

The purpose of the review is to evaluate the MCO's compliance with identifying and addressing member needs through:

- Comprehensive and timely screening;
- Comprehensiveness of care plan;
- Care management service delivery;
- Reviewing and updating the care plan;
- Discharge/transitional care follow-up after inpatient hospitalization; and
- Needs stratification, including Wisconsin Interdisciplinary Care Team (WICT) members.

MetaStar's review is conducted using criteria and reviewer guidelines approved by DHS, and based on the *Contract for BadgerCare Plus and/or Medicaid SSI HMO Services*, January 1, 2020 – December 31, 2021.

The CMR was conducted using a review tool and reviewer guidelines developed by MetaStar and approved by DHS.

Results for each CMR Focus Area

Each section below provides a brief explanation of a key CMR category, followed by a bar graph. The bar graphs represent the CY 2021 and CY 2020 state rates for each of the review indicators comprising the CMR category. The notes below each bar graph specify the number of applicable records when it is less than the total number reviewed. For each category, a record may be not met for more than one reason.

The review period included the early days of the COVID-19 public health emergency (PHE), including the Wisconsin *Safer at Home* order. The requirements of the *Safer at Home* orders may be a contributing factor in the results.

Screening

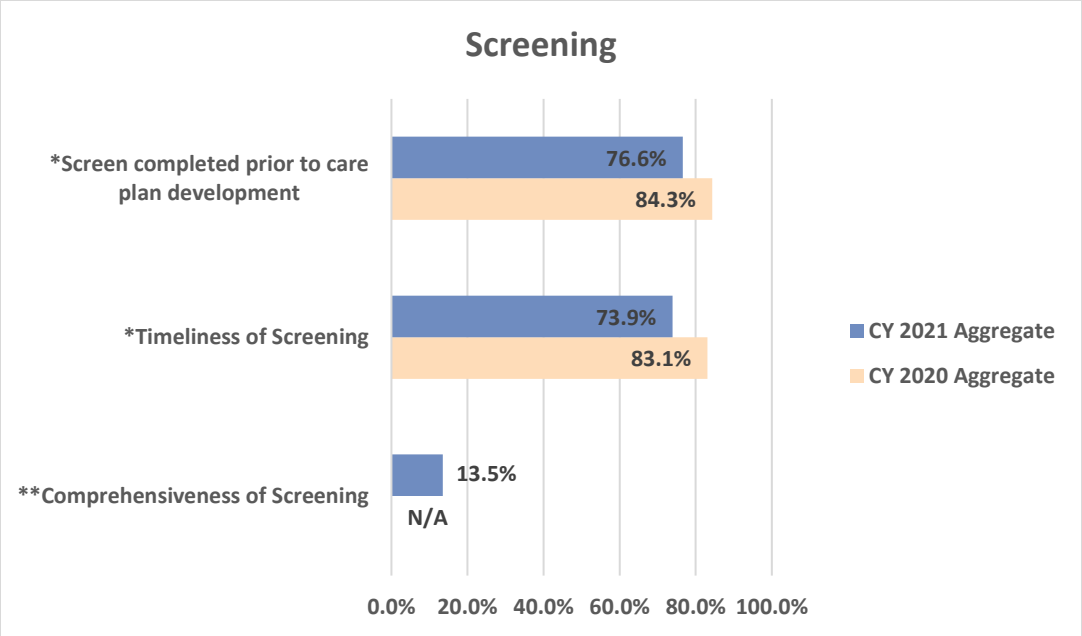
The MCO must identify all medical, dental, mental and behavioral health, or social needs of its members. The screening must be completed within 60 days of a new enrollment or within 30 days prior to the care plan for continuing enrollees. A comprehensive screening must include:

- 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.

Screening requirements applied to 765 of 800 records. The MCOs completed 73.9 percent of screenings within the required timeframes and 76.6 percent prior to or at the same time as completing the care plan. Analysis indicated the year-to-year difference in the screening completed prior to the care plan rates and timeliness of screening rates is unlikely to be the result of normal variation or chance.

The evaluation for comprehensiveness of the screening was newly evaluated in CY 2021. The MCOs were required to complete a comprehensive screening for all members either at the time of enrollment or annually. Of the members reviewed, 13.5 percent of the screenings were comprehensive. The majority of screenings found to not be comprehensive did not include an assessment of the members' perception of their strengths and general well-being.



*Note: The CMR category *Screening* applied to 765 of 800 records in CY 2021 and 765 of 800 records in CY 2020.
**Note: The review indicator *Comprehensiveness of Screen was a new indicator for the CY 2021 review and does not have previous results for comparison.*

Comprehensiveness of Care Plan

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

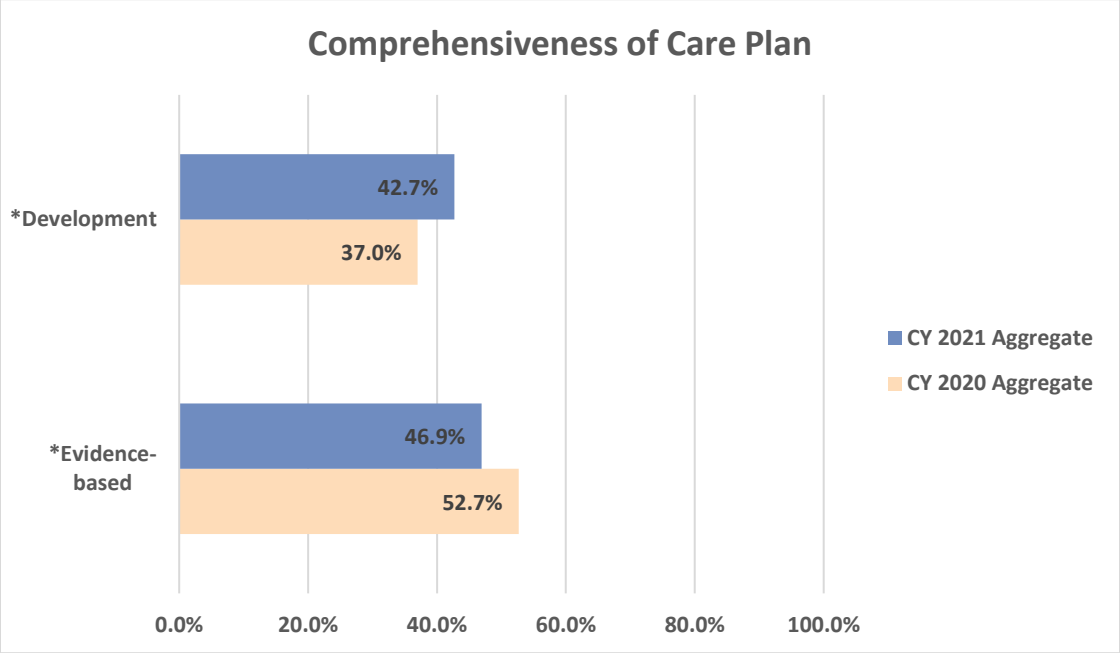
- Address all identified needs;
- Measure the member's readiness to change and engagement;
- Establish and prioritize specific short and long-term goals that are appropriate to address the member's needs; and
- Describe and sequence the interventions to address the identified needs.

Care plan requirements applied to 776 of 800 records. Approximately 47 percent of the records contained an evidenced-based care plan. The primary reasons care plans were not considered evidence-based was due to not containing goals that addressed the members' needs, were prioritized, or did not include interventions that were sequenced. Analysis indicated the year-to-year difference in the evidence-based rates is unlikely to be the result of normal variation or chance.

Nearly 43 percent of the records had a care plan developed with the member. The most common reasons for not met under care plan development was the care plan was not shared with the

member or PCP as required. Also, 54 percent did not contain evidence the member was in agreement with the care plan.

The MCOs completed most care plans telephonically. A small number were completed in-person, and none were completed via interactive video. Several records did not identify the mechanism used to complete the care plan. Analysis indicated the year-to-year difference in the development rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance.



*Note: The review indicators *Development* and *Evidence-based* applied to 776 of 800 records in CY 2021 and 767 of 800 records in CY 2020.

Care Management Service Delivery

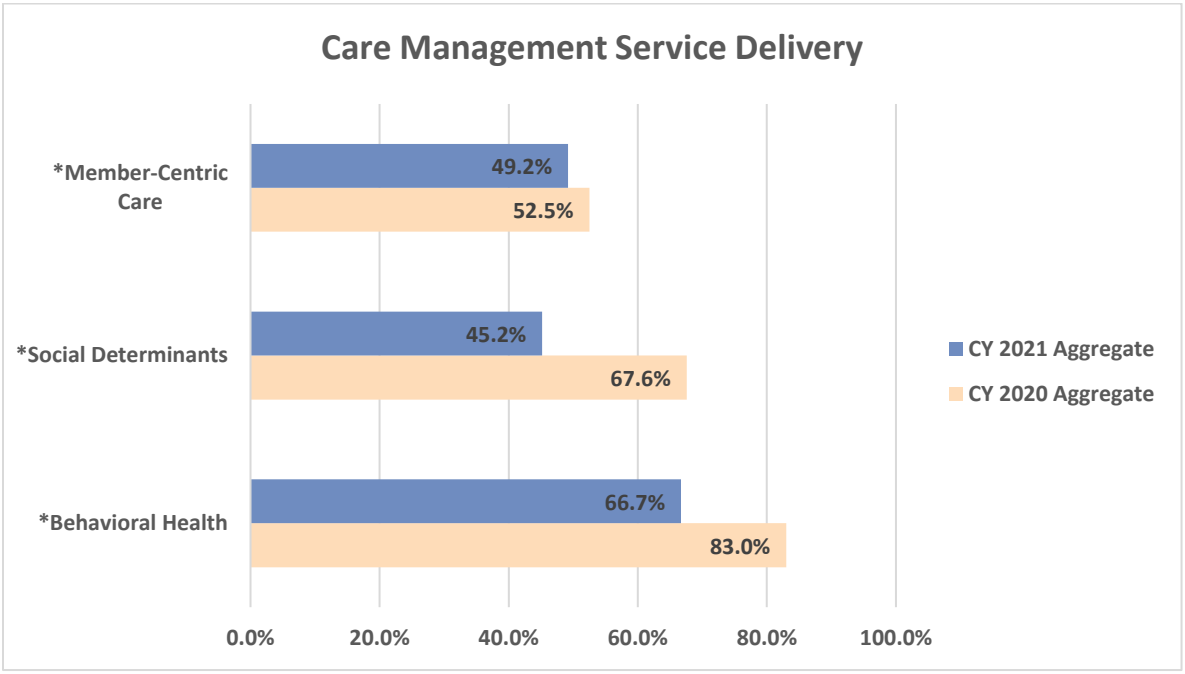
The MCO care management team is responsible for conducting service delivery activities. The service delivery must demonstrate member-centric care including:

- Regularly assessing a member's readiness to change and engagement;
- Assessing if the member's needs are being addressed according to the member; and
- Occur as frequently as needed to meet the member's needs and in alignment with the MCO's policies and procedures for the designated stratification level.

The service delivery of care management must also assure social determinant issues have actions in place until the need is addressed, and address all identified behavioral health issues. Analysis indicated the year-to-year difference in the member-centric rates is likely due to normal variation or chance.

Almost 50 percent of the records demonstrated member-centric service delivery. Of the records that did not meet the requirement, most did not evidence services occurred as frequently as needed to meet the member's needs and were not in alignment with the MCO's policies and procedures for the designated stratification level.

Social determinant issues or concerns were identified for approximately 45 percent of members during screening; however, no initial action or follow-up was included in the care plan for about half the members. Behavioral health needs were identified for 66.7 percent of members; however, follow-up activities were not evidenced in several of the members' records. Analysis indicated the year-to-year difference in the social determinants and behavioral health rates is unlikely to be the result of normal variation or chance.



*Note: The review indicator *Member-Centric Care* applied to 798 of 800 records in CY 2021 and 798 of 800 records in CY 2020. The review indicator *Social Determinants* applied to 376 of 800 records in CY 2021 and 374 of 800 records in CY 2020. The review indicator *Behavioral Health* applied to 547 of 800 records in CY 2021 and 559 of 800 records in CY 2020.

Care Plan Review and Update

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

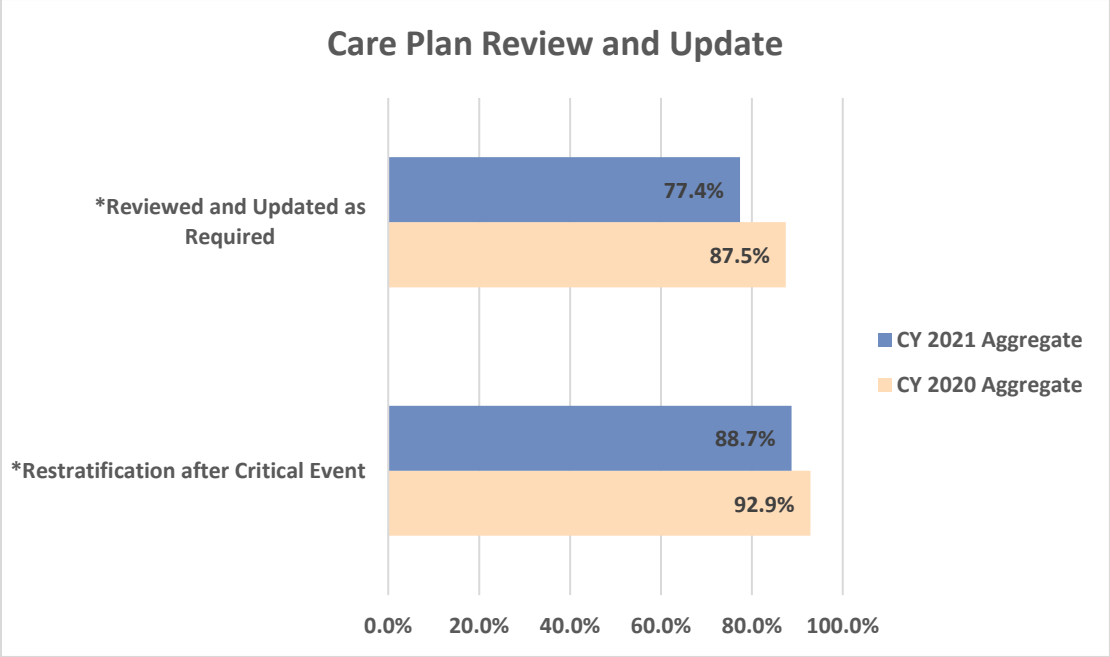
- Significant changes to medical and/or behavioral health needs;
- Changes in needs strata;
- Member non-responsiveness to the care plan;

- Frequent transitions between care settings; and
- Member request or identification of a problem/gap not previously addressed.

Care plan review and updates applied to 645 of 800 records. Of those, 77.4 percent contained evidence that the care plan was reviewed and updated with the member at least once during the review period.

Analysis indicated the year-to-year difference in the care plan review and update rates is unlikely to be the result of normal variation or chance.

Restratification after a critical event applied to 106 of 800 records. Approximately 11 percent of those records did not include evidence of restratification. Analysis indicated the year-to-year difference in the re-stratification rates is likely due to normal variation or chance.



*Note: The review indicator *Reviewed and Updated as Required* applied to 645 of 800 records in CY 2021 and 641 of 800 records in CY 2020. The review indicator *Restratified after Critical Event* applied to 106 of 800 records in CY 2021 and 154 of 800 records in CY 2020.

Discharge/Transitional Care Follow-Up

The MCO is responsible for having appropriate transitional care procedures to assist its members after discharge from a hospital. The follow-up activities should include:

- Conducting a medication reconciliation (or confirming the hospital completed);
- Reviewing discharge information with the member; and
- Providing assistance with scheduling follow-up appointments.

MetaStar collects and provides information to DHS and the MCOs about the total number of hospitalizations and how many hospitalizations had documented transitional care follow-up activities; however, this result is not represented in the graph.

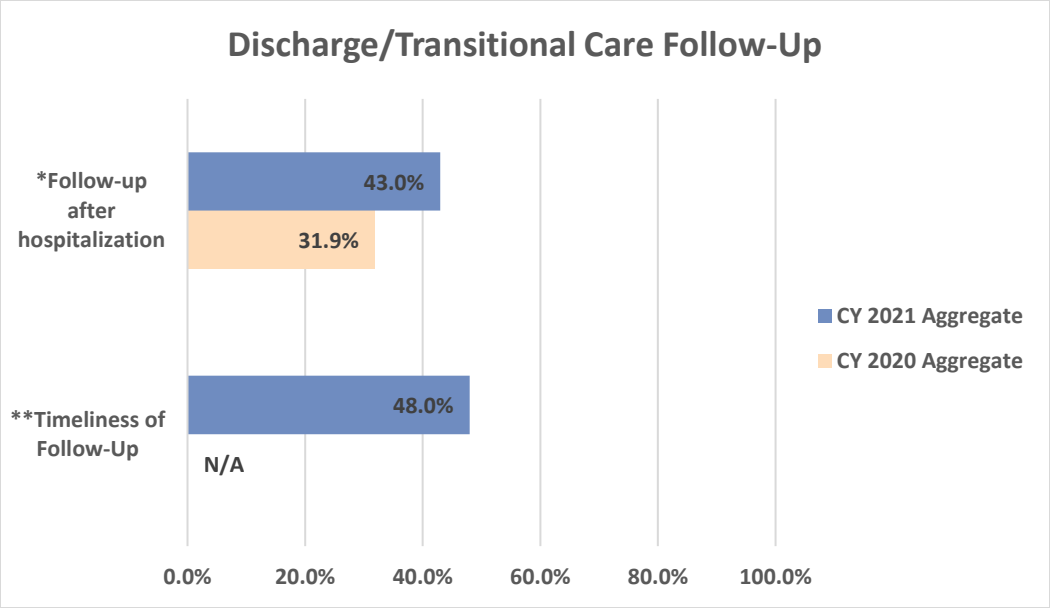
The rate of compliance for documenting transitional care follow-up after a hospitalization on a per record basis was 43 percent. The rate of compliance for documenting transitional care follow-up after a hospitalization in every instance was approximately 48 percent. During the prior review this indicator was only reported on a per record basis.

The rate of compliance for timeliness of transitional care follow-up on a per record basis was 48 percent. The rate of timeliness of follow-up in every instance was nearly 57 percent.

During the review period, 25 percent of members had at least one hospitalization during the review period requiring transitional care follow-up activities; however, 57 percent of those did not contain evidence of all required follow-up activities.

There were 379 total hospitalizations for 200 members. When follow-up activities were conducted, the MCOs completed 63 percent telephonically, about 2 percent were completed in-person, and no follow up was completed via interactive video. Of the records not meeting the requirement, 44.3 percent did not contain documentation of medication reconciliation completed by the hospital or the MCO; and 41.4 percent did not include documentation of a discharge instruction review.

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



*Note: The review indicator *Follow-Up after Hospitalization* applied to 200 of 800 records in CY 2021 and 263 of 800 records in CY 2020.
**Note: The review indicator *Timeliness of Follow-Up* was a new indicator in CY 2021 and comparable results are not available.

Wisconsin Interdisciplinary Care Team

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

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

Minimally, a team member of the WICT Core Team must meet once a month face-to-face with the member to discuss the member's care. Documentation of the meeting must identify:

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

Please note that the face-to-face visit indicator is scored on a per record basis. This means, for example, if a record identifies that four face-to-face visits are required, and the visit requirements are not documented for one of the visits, the indicator would be scored as *not met*. This result is represented in the following graph. MetaStar also collects and provides information to DHS and the MCOs about the total number of face-to-face visits and how many had met all visit requirements; however, this result is not represented in the graph. An exemption was granted from DHS for the WICT member face-to-face visit requirement during the PHE; however, member outreach via telehealth or telephone was a continued expectation.

The rate of compliance for documenting monthly face-to-face visits *on a per record basis* was almost 70 percent. The rate of compliance for documenting face-to-face visit requirements *in every instance* was nearly 86 percent. During the prior review this indicator was only reported aggregately.

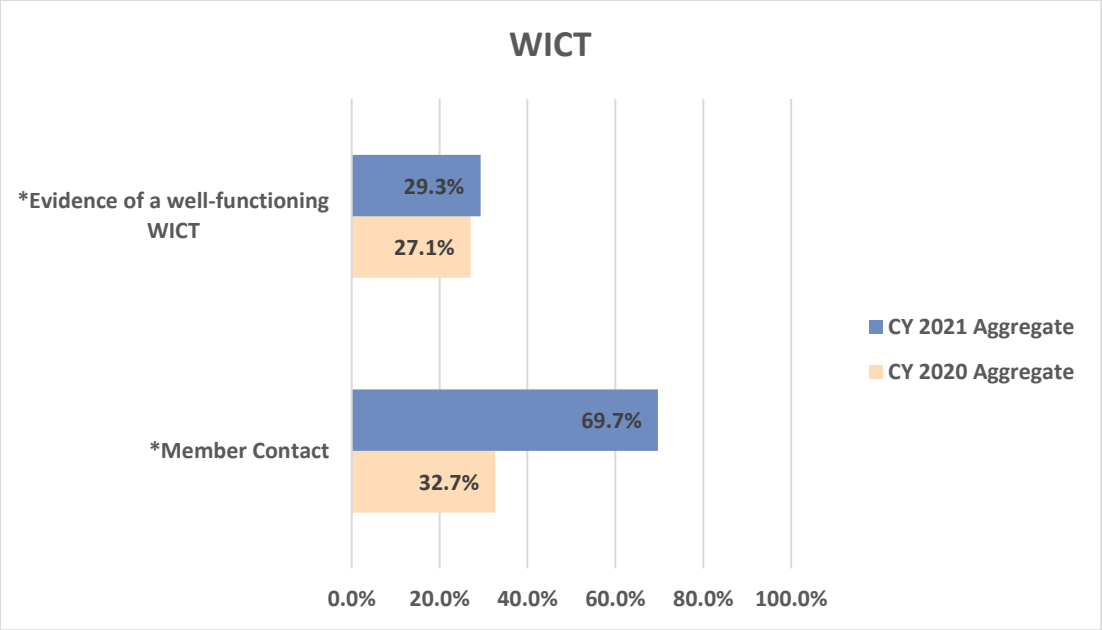
Almost 15 percent of members received WICT care management services during the review period. Of the records that did not contain evidence of a well-functioning WICT, 36 percent were missing evidence of the weekly core team meetings; and almost 46 percent did not contain evidence of core team collaboration.

However, nearly 70 percent of applicable WICT records contained evidence of all required face-to-face contact during WICT participation as required. However, this was most likely due to COVID-19 flexibilities which waived face-to-face requirements due to the PHE. Thirty-eight percent were scored as *not applicable* for face-to-face visits because WICT participation was less than a calendar month.

The following graph compares the MCO's rate at which the standards were met in CY 2021 and CY 2020.

Analysis indicated the year-to-year difference in the member contact rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance. However, as noted earlier, the increase was most likely due to the face-to-face requirement being waived during the PHE.

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



*Note: The review indicator *Evidence of a Well-Functioning WICT* applied to 116 of 800 records in CY 2021 and 155 of 800 records in CY 2020. The review indicator *Member Contact* applied to 76 of 800 records in CY 2021 and 113 of 800 records in CY 2020.

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

The review focused on five categories to evaluate program compliance:

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

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

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 2021 results for each indicator that comprises the category. CY 2020 results are provided for comparison.

Screening

Timeliness and Comprehensiveness of OHC Health Screen

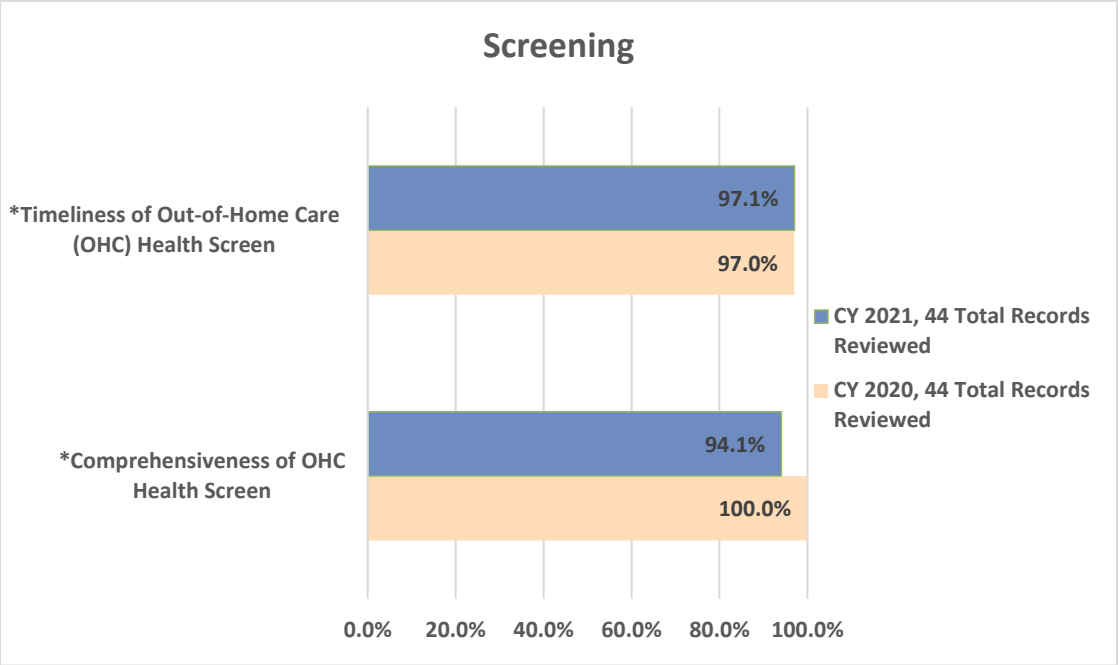
An Out-of-Home Care (OHC) Health Screen must be completed, communicated and followed-through within the timelines and conditions described in the DHS-FCMH contract.

Exemptions to the OHC Health Screen requirement are outlined in the DHS-FCMH contract. During the PHE, virtual (telehealth) format was permitted for the OHC Health Screens and could be postponed beyond two business days as needed.

Just over 97 percent of children had timely OHC Health Screens. Of those, 24 exceeded two business days, but were met with the PHE waiver. Of the screens completed, 96.9 percent were comprehensive. Nearly 23 percent of children were exempt from the OHC screening. Of those exempted, 80 percent were detained in the hospital at birth. Two were new enrollees into the program, but were not newly removed from the home.

The following graph compares the PIHP's rate at which the standards were met in CY 2021 and CY 2020. The OHC Health Screen was evaluated for comprehensiveness regardless of whether it was completed timely.

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



*Note: The review indicators *Timeliness of Out-of-Home Care (OHC) Health Screen* and *Comprehensiveness of OHC Health Screen* applied to 34 of 44 records in CY 2021 and 36 of 44 records in CY 2020.

Other Required Documentation if Exempt from OHC Health Screen

Documentation in the member record must also indicate prompt and adequate follow through occurred in relation to any immediate or emergent physical, mental/behavioral, and oral health needs identified during the OHC screening. Ten children were exempt from the OHC Health Screen. Triage scores and identification of immediate needs were included in those ten records.

Communication of Service Needs

The results of the OHC Health Screen must be communicated with those involved in the care and treatment of the child. Documentation in the member record must indicate the out-of-home caregiver is being provided with information to meet the identified needs of the child. The record must also show the OHC Health Screen information is shared with the child's out-of-home caregiver and child welfare case manager, and is sent to the care coordination team and PCP.

Communication of service needs were met for 63.6 percent of the children. Evidence of the screening results being communicated to the PCP as required were not documented in 29.5 percent of the records.

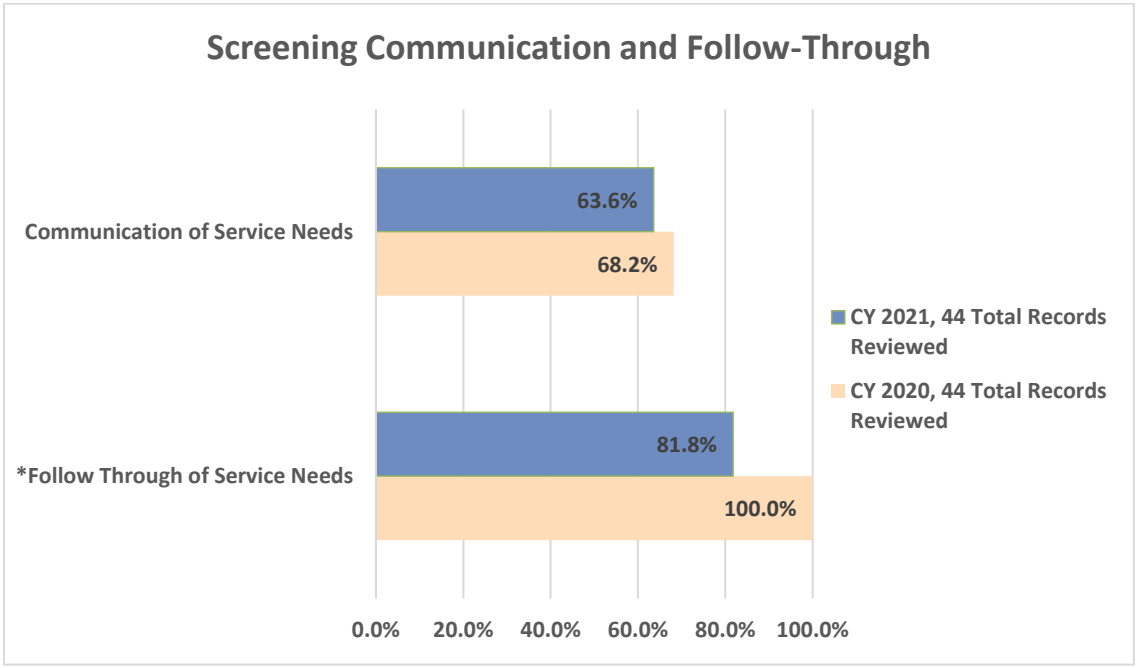
Follow Through of Service Needs

The PIHP is responsible for conducting follow-up activities. Documentation in the member record must indicate prompt and adequate follow through occurred in relation to any immediate or emergent physical, mental/behavioral, and oral health needs identified during the OHC screening.

OHC Health Screen results identified immediate or emergent needs for 25 percent of the children. Of the 25 percent, 18 percent records did not contain evidence of prompt and adequate follow through to address immediate physical health needs.

The following graph compares the PIHP's rate at which the standards were met in CY 2021 and CY 2020.

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



*Note: The review indicator *Follow Through of Service Needs* applied to 11 of 44 records in CY 2021 and three of 44 records in CY 2020.

ASSESSMENT

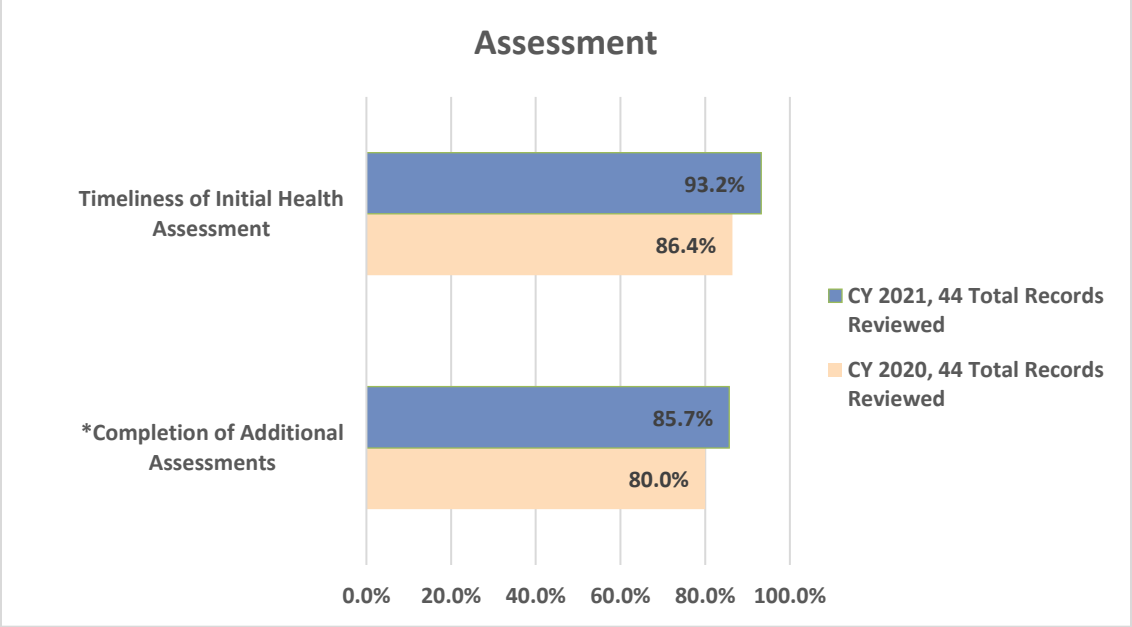
Timeliness and Completion of Initial Health Assessment

Records must contain evidence of a timely initial health assessment, including a HealthCheck exam. The records must also contain evidence that referrals were made and follow through occurred for each identified need. During the PHE, a virtual (telehealth) format was permitted for the Initial HealthCheck exam and the requirement for timeliness was extended from within 30 days of enrollment, to within 90 days of enrollment.

A timely Initial HealthCheck exam was documented for 93.2 percent of the children. Of those, 26.8 percent exceeded 30 days, but were met with the PHE waiver. Seventeen percent identified additional assessments were needed with 85.7 percent of those completed as indicated.

The following graph compares the PIHP's rate at which the standards were met in CY 2021 and CY 2020.

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



*Note: The review indicator *Completion of Additional Assessments* applied to seven of 44 records in CY 2021 and 15 of 44 records in CY 2020.

Referrals and Follow Through of Services Identified

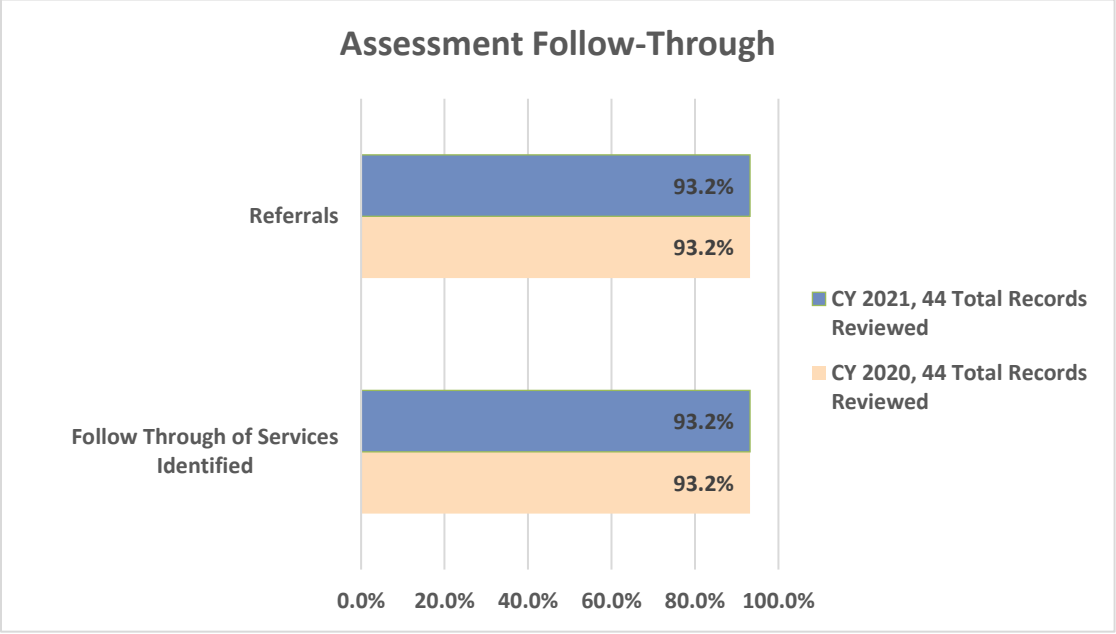
The record must document that appropriate referrals are made in a timely manner, based on the member's needs identified in the initial assessment. The record must also document that follow through is conducted in a timely manner to confirm the services and supports being coordinated

are in place, and the member's identified needs are being effectively addressed. If a child is not eligible for a specific referral/service, the record should show evidence of referral to an appropriate alternate service.

All applicable records contained evidence that timely follow through was conducted. None of the children required alternate supports. Three records were scored as *not met* because an Initial HealthCheck exam did not occur.

The following graph compares the PIHP's rate at which the standards were met in CY 2021 and CY 2020.

Analysis indicated the rates remained unchanged from the previous review.



Care Planning

Timeliness and Comprehensiveness of Initial Care Plan

The initial care plan must be completed within the first 60 calendar days of enrollment. Comprehensiveness is met when all requirements outlined in the contract are documented in the care plan.

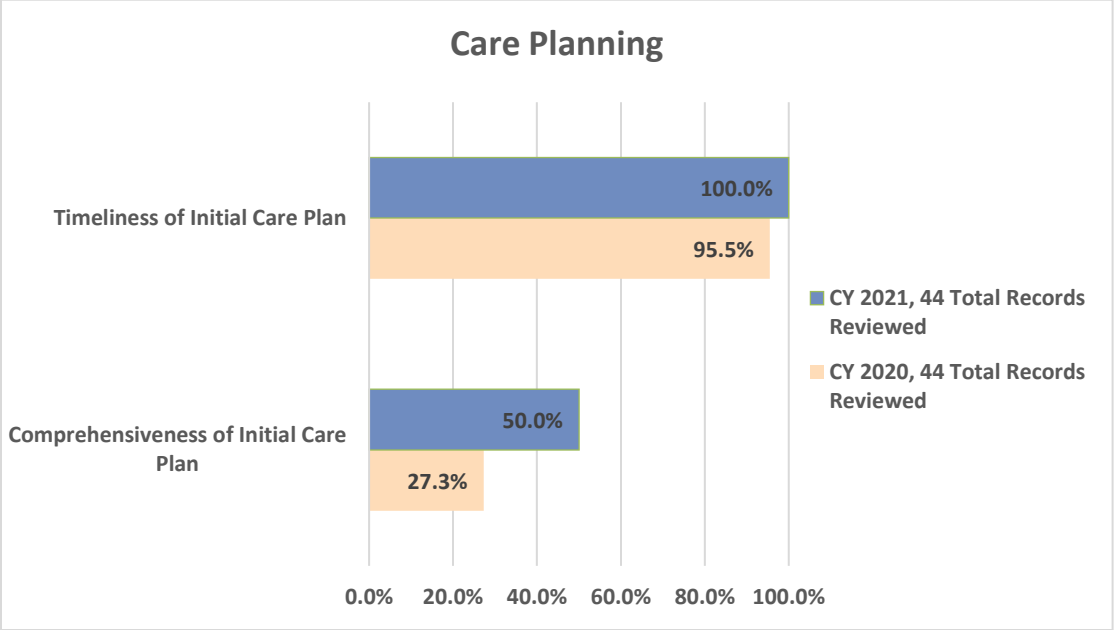
The care plan must identify the services and supports to be coordinated consistent with information in the initial comprehensive assessment; and must be developed and updated according to the timelines and conditions described in the DHS-FCMH contract.

All care plans were completed timely, but 50 percent did not meet the requirements for a comprehensive initial care plan. The contributing factors included:

- Lack of parent or legal guardian input, review, and sign-off of the care plan; and
- No evidence that the member's PCP, OHC caregiver, and child welfare caseworker were all the primary participants in the care plan development.

The following graph compares the PIHP's rate at which the standards were met in CY 2021 and CY 2020. The comprehensiveness rate reflects the rate of comprehension of the care plan regardless of timeliness.

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



CARE COORDINATION

Ongoing Collaboration and Communication

The record must document that services and supports were coordinated in a reasonable amount of time; that follow up with the member occurred in a timely manner to confirm the services/supports were received and were effective; and that all identified needs were adequately addressed. Nearly fourteen percent of records did not contain evidence of the required ongoing collaboration.

Monitoring for Emergent Needs, and Prioritizing Needs

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

Evidence of prioritizing identified needs was found in 93.2 percent of records. However, nearly seven percent did not contain evidence of ongoing monitoring to ensure the needs were addressed in a timely manner.

Coordinating Care

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

Follow Up

The record must document that timely follow-up is conducted to ensure the child is receiving all of the services identified in the care plan, and to determine whether the services are adequately meeting the child's needs. Eight-nine percent of records contained evidence of follow-up activities to ensure that the member was receiving identified services.

Plan Updated When Indicated

The care plan must be reviewed and updated at minimum every six months, and when the child has a significant change in situation or condition (e.g., the child has a hospitalization, a change in placement, is diagnosed with a new chronic condition, etc.). No care plans required a six-month review and update. Almost seven percent of the records needed a care plan update during the review period, but were not updated as required.

TRANSITIONAL HEALTH CARE PLANNING

Evidence of Transitional Health Care Planning

The record should document that transitional care planning occurred prior to a child leaving the FCMH. This requirement was not applicable to 97.8 percent of the records reviewed. A separate transitional plan and evidence of clear communication prior to disenrollment was missing from the 2.2 percent of applicable records.

CONCLUSIONS

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

APPENDIX V: INFORMATION SYSTEMS CAPABILITIES ASSESSMENT

The ISCA is a required part of other mandatory EQR protocols, such as Compliance with Standards and Performance Measure Validation (PMV). The ISCA is the review to ensure the ability of the managed care organization's information system to provide the state with all data elements the state deems necessary for the mechanized claims processing and information retrieval systems it uses for the management, monitoring, and administration of its Medicaid program.

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.

As a guide for conducting the ISCA, MetaStar used the *CMS External Quality Review (EQR) Protocols Appendix A. Information Systems Capabilities Assessment.* MetaStar reviewers collected information about the effect of the MCO's information management practices on data submitted to DHS. In addition to completing the ISCA scoring tool, MetaStar asked the MCO to submit documentation specific to its IS and operations used to collect, process, and report data. Reviewers also conducted staff interviews and observed demonstrations of the MCO's systems. For more detailed information about the review methodology, please see Appendix 2.

The ISCA review was revised at the start of this fiscal year to align with the Centers for Medicare & Medicaid Services External Quality Review Protocols, which define the review activities for Medicaid Managed Care Programs. This review was organized around and focused on the following categories:

- Section 1: Background Information;
- Section 2: Information Systems: Data Processing & Personnel;
- Section 3: Staffing;
- Section 4: Security; and
- Section 5: Data Acquisition Capabilities including:
    - Administrative Data;
    - Enrollment System;
    - Ancillary Systems;
    - Additional Data Sources that Support Quality Reporting; and
    - Integration and Control of Data and Performance Measure Reporting.

Summary and Analysis of Aggregate Results

Overall Results

During CY 2021, MetaStar conducted ISCAs for two PIHPs selected by DHS. The programs were Wraparound Milwaukee and Children Come First.

Compliance with ISCA requirements is expressed in terms of a percentage score and rating, as identified in the table below. See the Appendix 2 for more information about the scoring methodology.

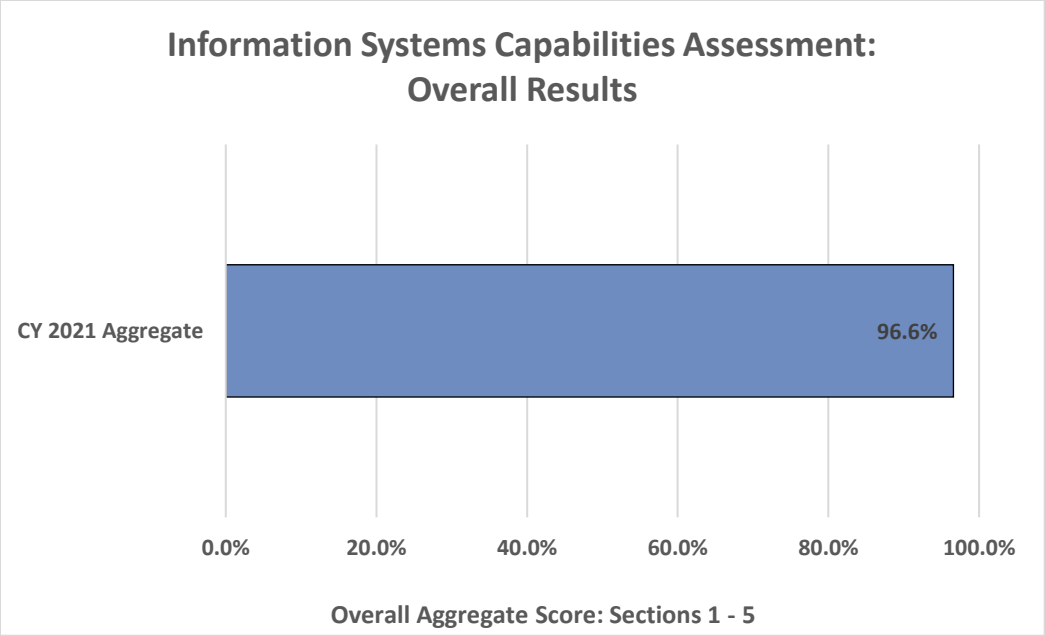
Scoring Legend	
Percentage Met	**Rating**
90.0% - 100.0%	EXCELLENT
80.0% - 89.9%	VERY GOOD
70.0% - 79.9%	GOOD
60.0% - 69.9%	FAIR
< 60.0%	POOR

Aggregately, the PIHPs had an overall score of 96.6 percent, and a rating of Excellent.

Information Systems Capabilities Assessment CY 2021			
Focus Area	**Scoring Elements**	**Percentage**	**Rating**
Background Information*	NA	NA	NA
Information Systems	42/42	100.0%	EXCELLENT
Staffing	4/4	100.0%	EXCELLENT
Security	50/52	96.2%	EXCELLENT
Data Acquisition	129/135	95.6%	EXCELLENT
Overall	**225/233**	**96.6%**	**EXCELLENT**

Note: *Section 1: Background Information is not scored.

The graph on the next page illustrates the overall compliance with these standards.



OBSERVATION AND ANALYSIS FOR EACH ISCA FOCUS AREA

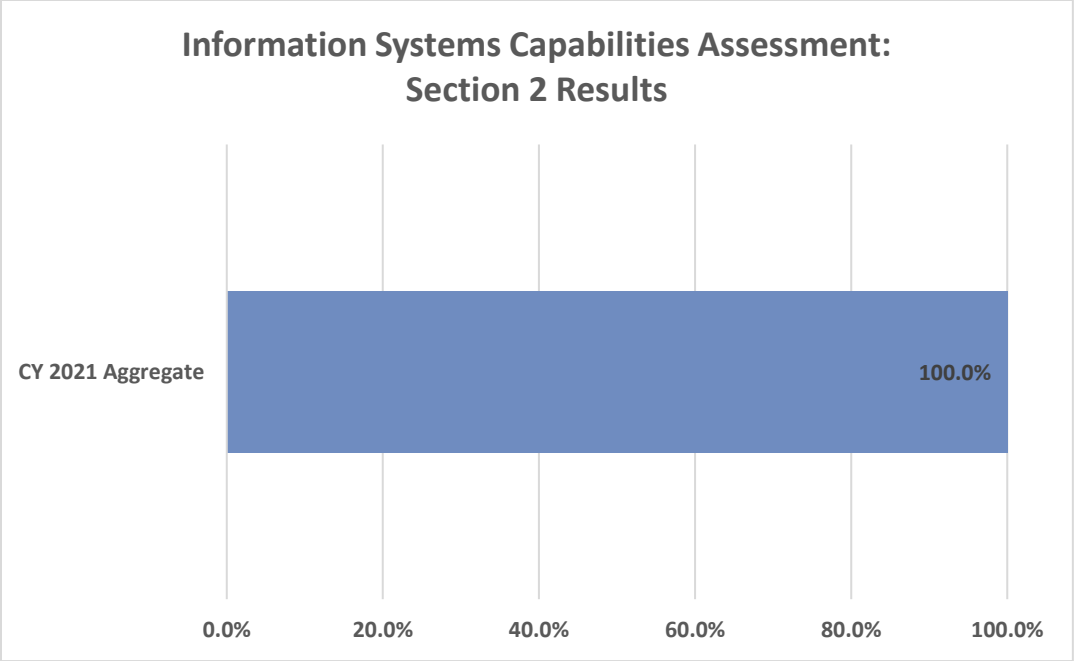
Section 1. Background Information

The PIHPs must detail the type of managed care program operated, 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. Both PIHPs provided the requested information.

Section 2. Information Systems - Data Processing & Personnel

The PIHP must have a system or repository used to store Medicaid claims and encounter data supported by stable and experienced IS staff. The IS department should follow a standardized process when updating and revising code. This process should include safeguards that ensure that the correct version of a program is in use. Aggregately, Section 2 contains 42 scoring elements. The PIHPs satisfied requirements for 42 out of 42 scoring elements, for a score of 100 percent, and a rating of Excellent.

The graph on the next page illustrates aggregate overall compliance with these requirements.

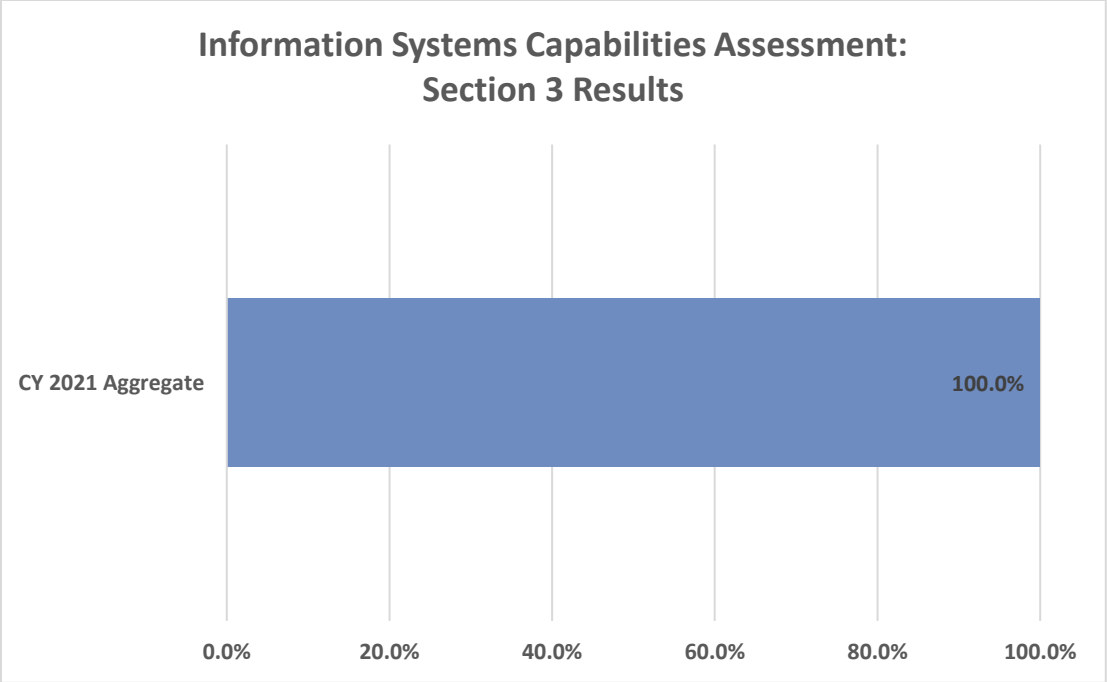


The responses submitted and interview sessions met requirements of this standard. Both PIHPs use internally developed, intranet-based applications. All updates and changes follow a standard software development methodology and version control to ensure ongoing integrity of the systems.

Section 3. Staffing

The PIHP IS department must provide its new employees with on-the-job training and supervision. Supervisors should closely audit the work of new hires before concluding the training process. Seasoned processors should have occasional refresher courses and training concerning any system modifications. Expected productivity goals should not be unusually high, thus having a negative impact on the accuracy and quality of a processor's work. Aggregately, Section 3 contains four scoring elements. The PIHP satisfied requirements for four out of four scoring elements, for a score of 100 percent, and a rating of Excellent.

The graph on the next page illustrates aggregate overall compliance with these requirements.

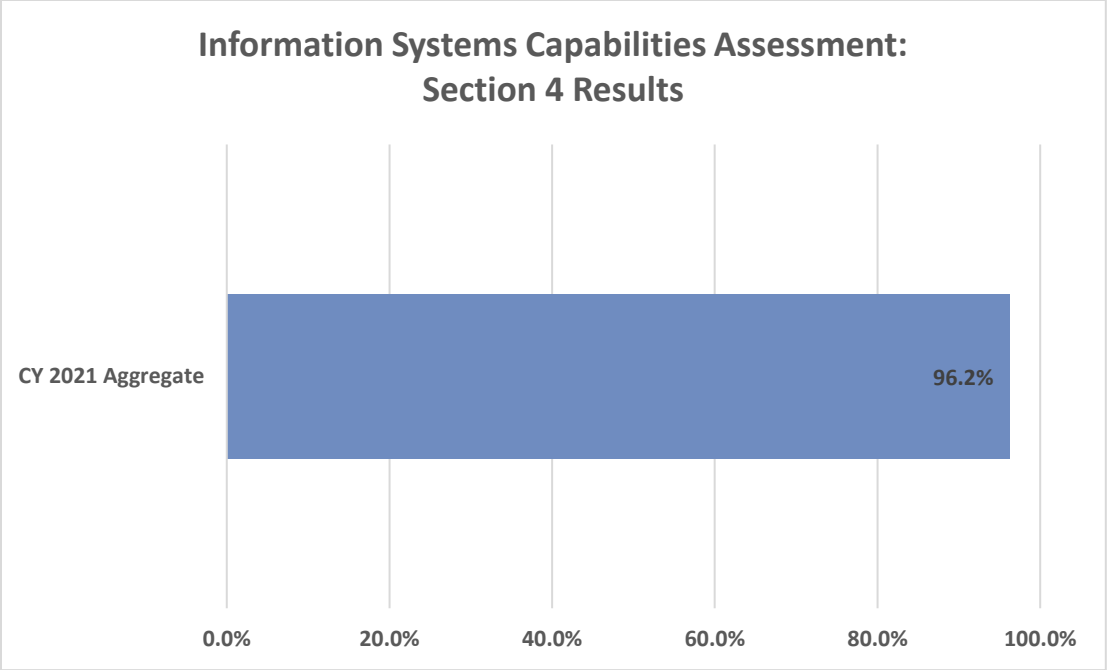


The responses submitted and interview sessions met requirements of this standard. The PIHPs reported robust initial training process and low staff turnover. Both organizations monitor productivity ongoing.

Section 4. Security

The PIHPs must have strong IS security controls that protect from both unauthorized usage and accidental damage. Practices must be in place to manage its encounter data security processes and ensure the data integrity of submissions. PIHPs should have data backing and disaster recovery procedures, including testing. Aggregately, Section 4 contains 52 scoring elements. The PIHPs satisfied requirements for 50 out of 52 scoring elements, for a score of 96.2 percent, and a rating of Excellent.

The graph on the next page illustrates aggregate overall compliance with these requirements.



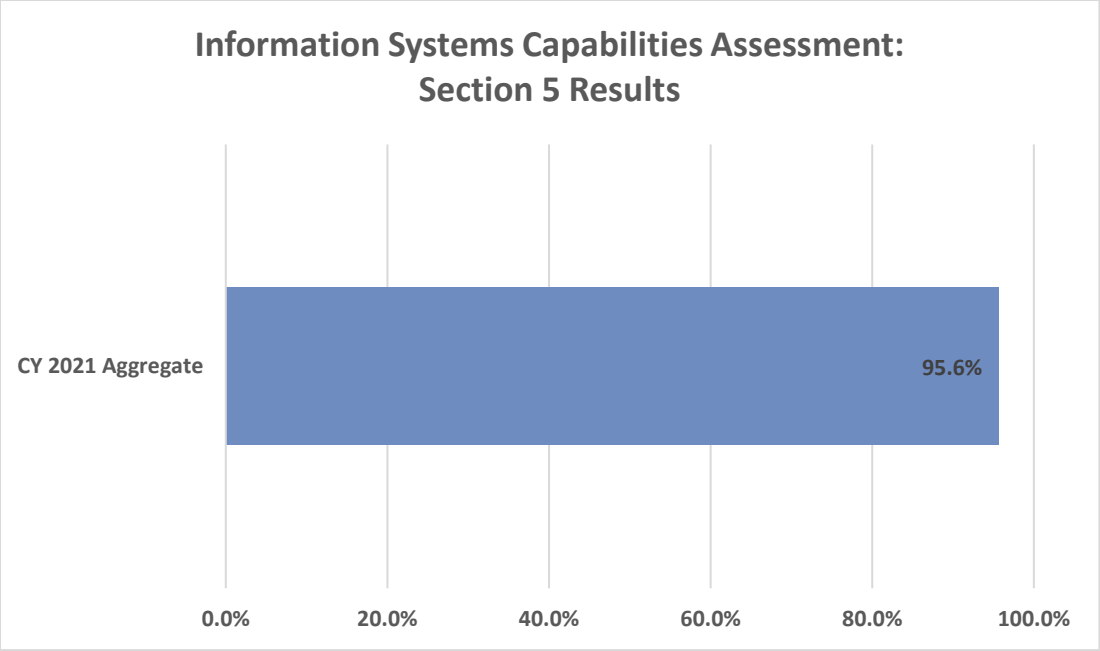
The responses submitted and interview sessions met most requirements of this standard. The PIHPs security practices generally align with industry standards.

Scoring element 4.12a requires completed testing of the FIPS, which are federally established standards and guidelines for use in computer systems for non-military government agencies and government contractors. At the time of the reviews, the organizations were in process of or had completed the transition to FIPS-compliant software, and neither had conducted a FIPS 140-2 test. MetaStar recommends the PIHPs develop and implement a process to routinely conduct the FIPS 140-2 tests to ensure full compliance and the integrity of its data.

Section 5. Data Acquisition Capabilities

PIHPs must have consistent processes for collecting and maintaining administrative data (claims and encounter data), enrollment data, ancillary services data and data related to performance rates reporting. Aggregately, Section 5 contains 135 scoring elements. The PIHPs satisfied requirements for 129 out of 135 scoring elements, for a score of 95.6 percent, and a rating of Excellent.

The following graph illustrates aggregate overall compliance with these requirements.



Data acquisition is comprised of five sub-sections including Administrative Data, Enrollment System, Ancillary System, Additional Data Sources that Support Quality Reporting, and Integration and Control of Data for Performance Measure Reporting. The results of each sub-section are described below.

5A. Administrative Data (Claims and Encounter Data)

This section focuses on input data sources, such as electronic and paper claims, and on the transaction systems utilized by the PIHPs. The responses submitted and interview session met most of the requirements in this subsection for one PIHP. The other PIHP met all requirements. Both PIHPs have 99 percent or greater of all claims submitted electronically.

Elements 5A.6 and 5A.6a are about including all diagnoses and the ability to distinguish the primary and secondary diagnoses. One PIHP reported its claims only allow for a single diagnosis and only one is reported per encounter. MetaStar recommends the PIHP update its internal software application and encounter submissions to include all diagnoses, as required.

5B. Enrollment System

This section focuses on the processing and management of enrollment data. The responses submitted and interview session met most of the requirements in this subsection for one PIHP. The other PIHP met all requirements. Each enrollment segment has a new enrollment date assigned and members are disenrolled from other Medicaid programs prior to enrollment with the PIHPs.

Element 5B.2 is about the quality of the PIHP's Medicaid data. One PIHP confirmed during the interview session that allowing procedure codes to have active/inactive dates was not designed into its system and a work-around process has been used since 2008 to enter backdated claims. This does not satisfy the requirements for this section. Additionally, Element 5B.6 is about minimizing the opportunity for duplicate members to be entered into the system. The PIHP did not use an automated system to catch and resolve duplicate entries. Although new members were enrolled daily as needed, the PIHP did not clearly describe how breaks in enrollment were accounted for and resolved. MetaStar recommends one PIHP update its internal database application to eliminate the work-around system, automate the process for uncovering and resolving duplicate entries, and automate calculation of continuous enrollment for each member.

5C. Ancillary Systems

This section focuses on use and oversight of third-party data. Neither PIHP uses third-party data. As such, this section is not applicable.

5D. Additional Data Sources that Support Quality Reporting

This section focuses on data sources beyond third party collection of claims or encounter data that support quality reporting. Neither PIHP uses other data sources to support quality reporting. As such, this section is not applicable.

5E. Integration and Control of Data for Performance Measure Reporting

This section focuses on how the PIHPs integrate Medicaid claims, encounter, membership, provider, third-party, and other data to calculate performance rates. The PIHPs do not report Medicaid performance measures. As a result, many indicators were not applicable. However, the responses submitted and interview sessions met the provider elements of this subsection.

CONCLUSIONS

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

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

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

Results for each CMR Focus Area

Each of the five sub-sections below provides a brief explanation of a key CMR category, followed by bar graphs which display aggregate CY 2021 results for each indicator that comprises the category. CY 2020 aggregate results are provided for comparison.

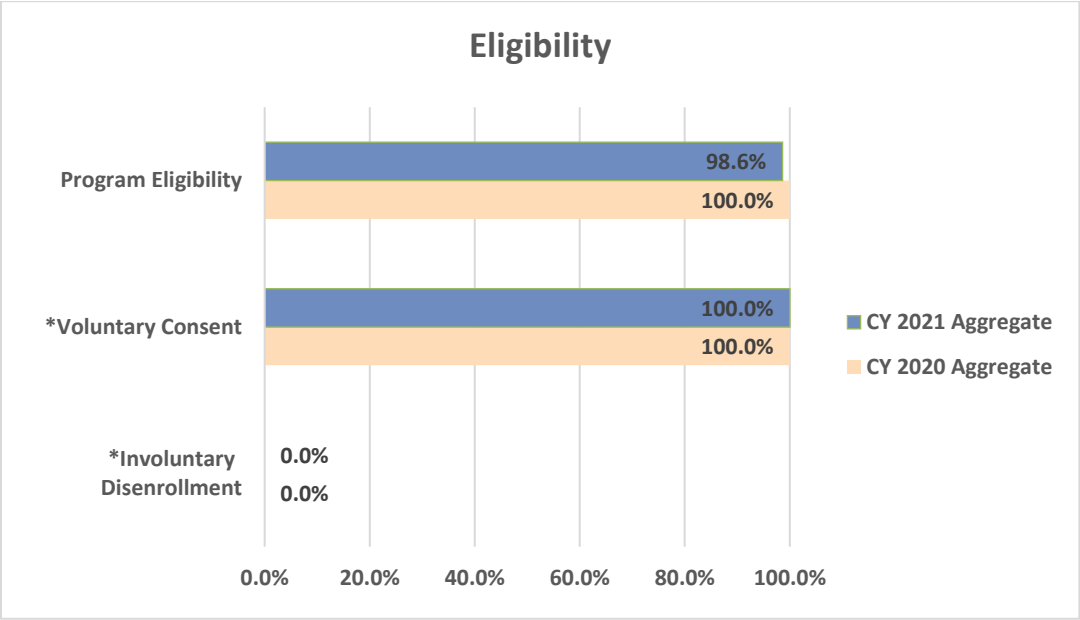
Eligibility

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 10 or more visits to tertiary clinics within the preceding year. Members too young to meet the utilization criteria may be eligible if the health condition criteria is met, and a hospital stay totaling five or more days, or clinicians anticipate ongoing high utilization.

Most records reviewed for both hospitals contained evidence that the members met or continued to meet the eligibility requirements. Approximately 11 percent of members were newly enrolled during the review period and all records included documentation of voluntary consent to participate in the program. No members were involuntarily disenrolled during the review period; therefore, the *Involuntary Disenrollment* indicator was not applicable.

The following graph compares the aggregate rate at which the eligibility standards were met in CY 2021and CY 2020.

Analysis indicated the year-to-year difference in the eligibility rates is likely due to normal variation or chance. Analysis indicated the voluntary consent rates remain unchanged from the previous review.



*Note: The review indicator *Voluntary Consent* applied to 8 of 70 records in CY 2021 and 5 of 60 records in CY 2020. The review indicator *Involuntary Disenrollment* did not apply to any records in CY 2021 or CY 2020

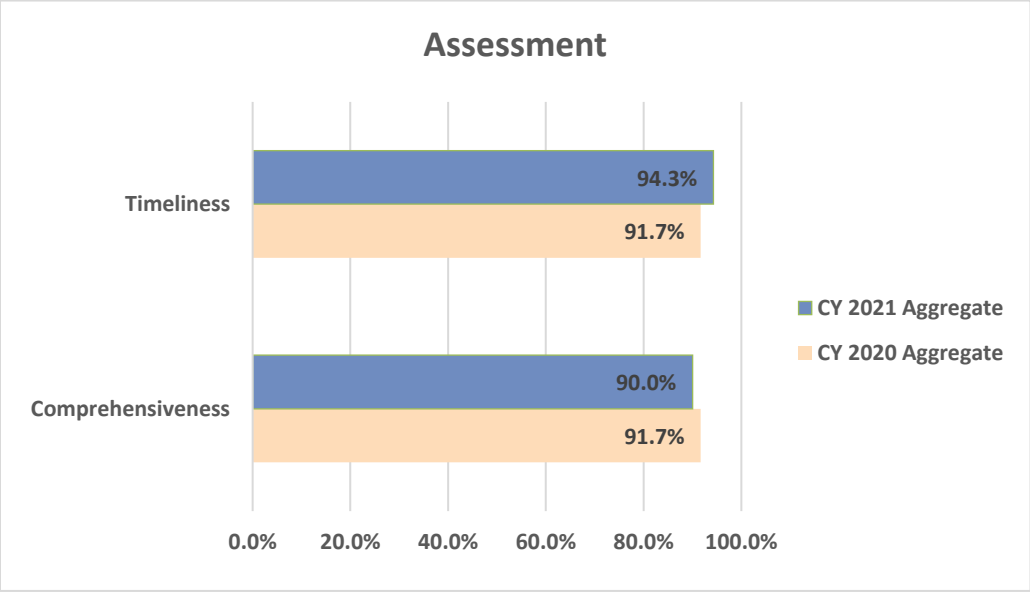
ASSESSMENT

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.

Timely assessments were completed in 94.3 percent of the records reviewed. Of those, 90 percent were comprehensive. The remaining records did not contain documentation of a completed assessment during the review period.

The following graph compares the aggregate rate at which the assessment standards were met in CY 2021 and CY 2020. The comprehensiveness rate reflects the rate of comprehension of the assessment regardless of timeliness.

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



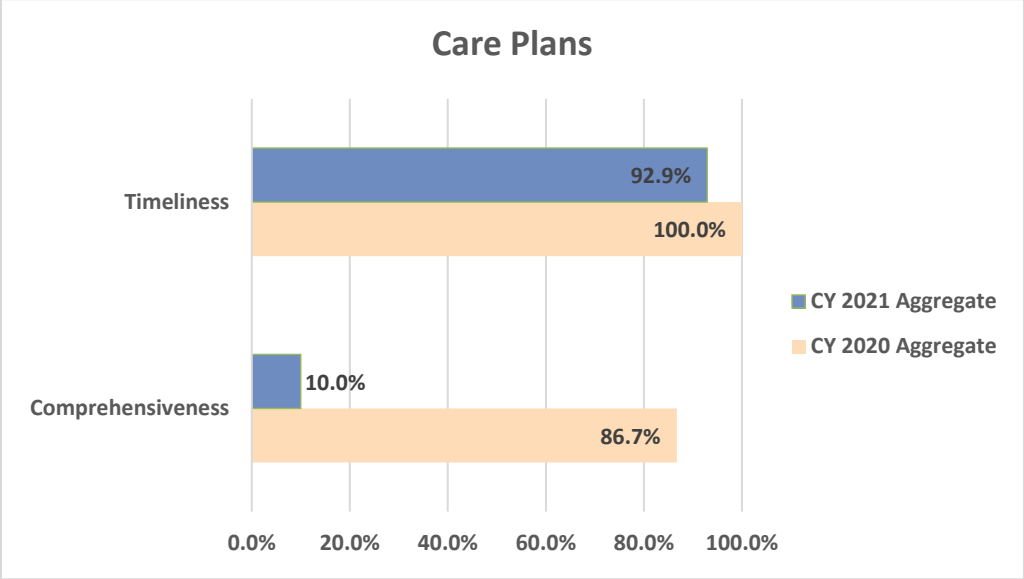
Care Planning

Each member must have a comprehensive care plan completed within 30 days of enrollment and initial assessment. A care plan is comprehensive when it contains the member's needs and goals (medical, social, and educational); identifies the actions or interventions to meet the goals; and indicates timeframes for the interventions. The 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.

Timely care plans were completed in 92.9 percent of records reviewed. Comprehensive care plans were completed in 10.0 percent of records reviewed. Reviewers looked for evidence of goals that were specific, measurable, achievable, relevant, and timely (SMART). The 90.0 percent scored not met for this indicator was primarily because the care plans did not contain evidence of all SMART criteria.

The following graph compares the aggregate rate at which the care plan standards were met in CY 2021 and CY 2020. The comprehensiveness rate reflects the rate of comprehension of the care plan regardless of timeliness.

Analysis indicated the year-to-year difference in the comprehensiveness rates is unlikely to be the result of normal variation or chance. Analysis indicated the year-to-year difference in the timeliness rates is likely due to normal variation or chance.

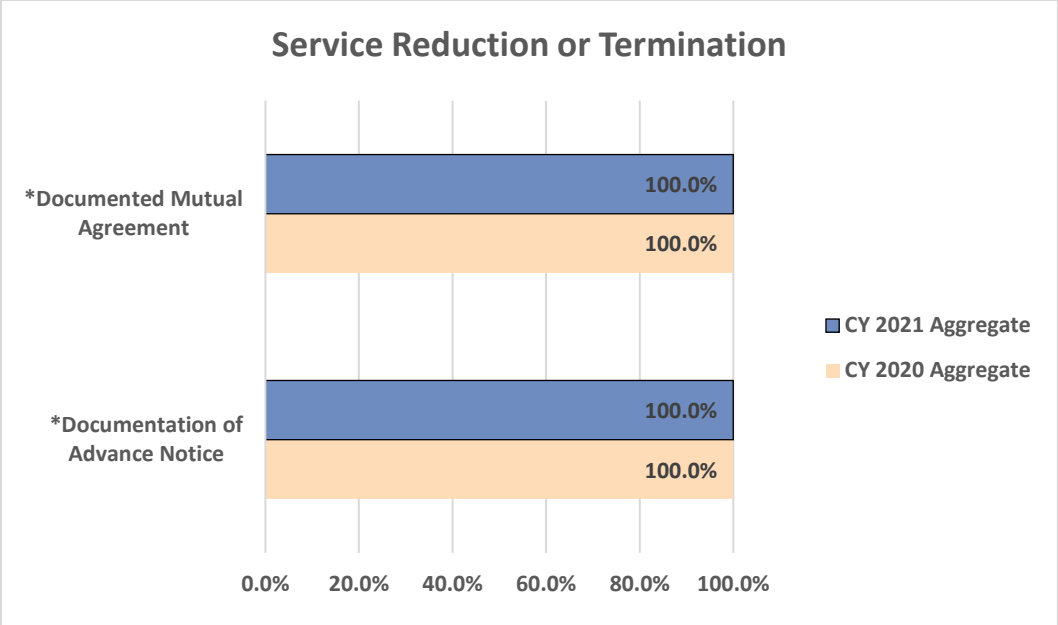


Service Reduction or Termination

All service reductions or terminations must be mutually agreed upon and the changes communicated to the legal decision maker in advance. This requirement applied to 7.1 percent of the records and all met the requirements for both mutual agreement and advance notice.

The following graph compares the aggregate rate at which the service reduction or termination standards were met in CY 2021 and CY 2020.

Analysis indicated the mutual agreement and advance notice rates remain unchanged from the previous review.



*Note: The review indicators *Documented Mutual Agreement* and *Documentation of Advance Notice* applied to 5 of 70 records in CY 2021 and 1 of 60 records in CY 2020.

Monitoring and Service Coordination

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

Ongoing monitoring and service coordination activities were completed as required in 93.5 percent of records. Documentation demonstrating member needs were addressed was identified in 94.3 percent of records.

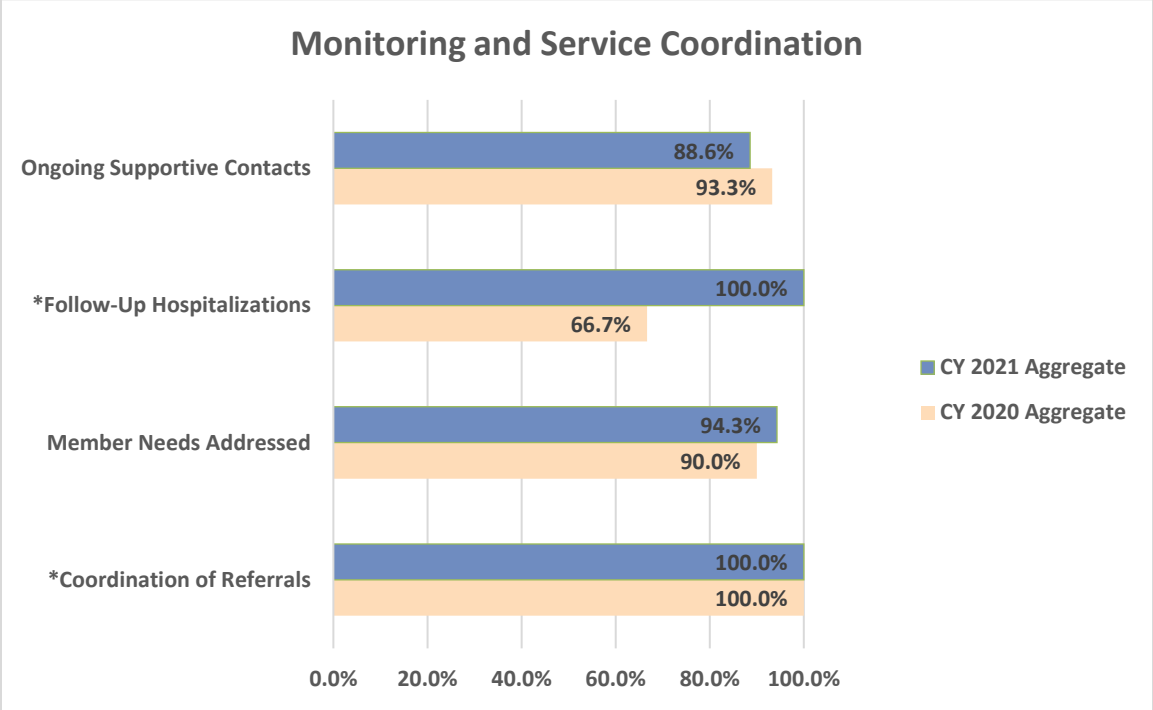
Follow-up after hospitalization applied to 21.1 percent of records. Of those, all met the requirement. The remaining records did not indicate a hospitalization during the review period.

Coordination of Referrals applied to 44.3 percent of the records. Of those, all met the requirements. The remaining records did not indicate a referral need during the review period.

The following graph compares the aggregate rate at which the monitoring and service coordination standards were met in CY 2021 and CY 2020.

Analysis indicated the year-to-year difference in the Follow-Up Hospitalizations rates is likely attributable to actions of the hospital, and is unlikely to be the result of normal variation or chance. Analysis indicated the year-to-year difference in the Ongoing Supportive Contacts and

Member Needs Addressed rates is likely due to normal variation or chance. Analysis indicated the *Coordination of Referrals* rates remain unchanged from the previous review.



*Note: The review indicator *Follow-Up Hospitalizations* applied to 15 of 70 records in CY 2021 and 18 of 60 records in CY 2020. The review indicator *Coordination of Referrals* applied to 31 of 70 records in CY 2021 and 20 of 60 records in CY 2020.

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

AAAHC	Accreditation Association for Ambulatory Health Care
AFCH	UW Health – American Family Children's Hospital
Anthem	Anthem Blue Cross and Blue Shield Health Plan
BC+	BadgerCare Plus
CBP	Controlling Blood Pressure
CCF	Children Come First
CCHP	Children's Community Health Plan, Inc.
CDC	Comprehensive Diabetes Care
CFR	Code of Federal Regulations
CHW	Children's Hospital of Wisconsin
CIS	Childhood Immunization Status
CMC	Children with Medical Complexities
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CW	Care Wisconsin
CY	Calendar Year
DHP	Dean Health Plan, Inc.
DHS	Wisconsin Department of Health Services
EQR	External Quality Review
EQRO	External Quality Review Organization
FCMH	Foster Care Medical Home
FUH	Follow-Up After Hospitalization for Mental Illness
GHC-EC	Group Health Cooperative of Eau Claire
GHC-SCW	Group Health Cooperative of South Central Wisconsin
HbA1c	Hemoglobin A1c
HEDIS[4]	Healthcare Effectiveness Data and Information Set

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

HIV	Human Immunodeficiency Virus
*i*Care	Independent Care Health Plan
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
ISCA	Information Systems Capabilities Assessment
LSC	Lead Screening in Children
MCHP	MercyCare Health Plans
MCO	Managed Care Organization
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
PCP	Primary Care Provider
PDSA	Plan-Do-Study-Act
PHE	Public Health Emergency
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PPC	Prenatal and Postpartum Care
Quartz	Quartz Health Solutions, Inc.
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 40 years, and represents Wisconsin in the Superior Health Quality Alliance, under the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization Program.

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

MetaStar Review Team

The MetaStar EQR team is comprised of registered nurses, a clinical nurse specialist, a physical therapist, a recreational therapist, a school counselor, licensed and/or certified social workers, and other degreed professionals with extensive education and experience working with the target groups served by the MCOs. The EQR team is supported by other members of MetaStar's 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®)[5] auditor, certified professional coders, and information technologies staff. Review team experience includes professional practice and/or administrative experience in managed health and long-term care programs as well as in other settings, including community programs,

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

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[6]: Validation of Performance Improvement Projects (PIP)

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

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

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

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

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

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

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

CMS External Quality Review (EQR) Protocols, Protocol 2: Validation of Performance Measures

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

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 2020 DHS eliminated its state-developed measures and transitioned its P4P measures to two BC+ and one SSI composites. The BC+ composites were made up of a women's health composite (two HEDIS measures) and a children's health composite (three 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.

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

QCR, a mandatory EQR activity, evaluates policies, procedures, and practices which affect the quality and timeliness of care and services provided to MCO members, as well as members' access to services. The MetaStar team evaluated MCOs' compliance with standards according to 42 CFR 438, Subpart E using the CMS guide, *CMS External Quality Review* (*EQR) Protocols, Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations, A Mandatory Protocol for External Quality Reviews (EQR).*

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

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

- The MCO's current contracts with DHS;
- Related program operation references found on the DHS website:
  - https://www.dhs.wisconsin.gov/familycare/mcos/index.htm;
- The previous external quality review report; and
- DHS communication with the MCO about expectations and performance during the previous 12 months.

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

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

MetaStar 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 • 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 the National Committee for Quality Assurance (NCQA) and organizations accredited by an accrediting body not accepted by DHS.

MCO	Last Compliance Review	Next Compliance Review
GHC-EC	2019	2022
*i*Care	2021	2024

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

Prior to conducting care management review in calendar year 2020 each MCO was asked to respond in writing to a survey, which asked the organization to describe its processes for:

- Identifying and contacting members;
- Needs stratification;
- Care management structure;
- Care planning process;

- Transitional care; and
- Wisconsin Interdisciplinary Care Team (WICT) structure and processes.

MetaStar also obtained and reviewed MCO documents to familiarize reviewers with the MCO's practices, including policies, procedures, and/or forms related to member outreach, assessment and care planning, member acuity or level of care intensity for care management, and care coordination activities such as follow-up.

Per DHS direction, MetaStar randomly selected a sample of new and continuing SSI members who were enrolled for at least 90 consecutive days between January 1, 2020 and December 31, 2020.

The review team used a tool and guidelines based on the DHS-MCO contract and agreed upon with DHS. The review evaluated the following six categories of care coordination and care management. The six categories were made up of twelve indicators that reviewers used to evaluate care management performance:

1. Screening
    a. Screening completion prior to care plan development
    b. Timeliness of screening
    c. Comprehensiveness of screening
2. Comprehensiveness of Care Plan
    a. Development of care plan
    b. Evidence based
3. Care Management Service Delivery (Follow-Up)
    a. Member-centric care
    b. Social determinants
    c. Behavioral health
4. Care Plan Review and Update
    a. Reviewed and updated as required
    b. Restratification after a critical event
5. Discharge/Transitional Care Follow-Up
    a. Follow-up after hospitalization
    b. Timeliness of follow-up after hospitalization
6. WICT
    a. Evidence of a well-functioning WICT
    b. Member contact

MetaStar used a binomial scoring system (*met* and *not met*) to evaluate the presence of each required element in the sample of member records. For findings of *not met*, the reviewers noted the key areas related to the finding and provided comments to identify the missing requirements.

In addition, when an initial screening or annual care plan was not completed, all elements were scored *not met*.

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

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

Prior to conducting the review, MetaStar obtained and reviewed the organization's documents to familiarize reviewers with the practices, including policies, procedures, and/or forms related to member assessment and care planning, member acuity or level of care intensity, and care coordination activities such as follow-up.

Per DHS direction, MetaStar randomly selected a sample of FCMH members who were newly enrolled on or after January 1, 2020 and who were enrolled at least 60 consecutive days.

The review team used a review tool and reviewer guidelines based on the DHS-MCO contract and agreed upon with DHS. The review evaluated the following five categories of care coordination and management. The five categories were made up of 17 indicators that reviewers used to evaluate care management performance:

2. Screening
    a. Timeliness of Initial Out-of-Home Care (OHC) Screen
    b. Comprehensiveness of OHC Screen
    c. Communication of Service Needs
    d. Follow-Through of Service Needs
3. Assessment
    c. Timeliness of Initial Health Assessments
    d. Completion of Additional Assessments
    e. Referrals
    f. Follow-through of Services Identified
4. Care Planning
    a. Timeliness of Initial Care Plan
    b. Comprehensiveness of Initial Care Plan
5. Care Coordination
    a. Ongoing Collaboration and Communication
    b. Monitoring for Emergent Needs
    c. Prioritizing Needs
    d. Coordinating Care
    e. Follow-Up
    f. Plan Updated when Indicated
6. Transitional Health Care Planning

a. Planning for members returning to parents, but remaining in the FCMH
b. Planning for members disenrolling from the FCMH

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

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

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.

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.

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 Complexities

Prior to conducting the review, MetaStar obtained and reviewed the organization's documents to familiarize reviewers with the practices, including policies, procedures, and/or forms related to member assessment and care planning, member acuity or level of care intensity, and care coordination activities such as follow-up.

Per DHS direction, MetaStar randomly selected a sample of CMC members who were enrolled as of September 30, 2020, and who were enrolled at least 60 consecutive days.

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 five categories were made up of thirteen indicators that reviewers used to evaluate care management performance:

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

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

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

Appendix 3 – Compliance with Standards Review: CY 2021 MCO Comparative Scores

Standard	Citation	BC+ and SSI Managed Care Programs CY2021						
		Anthem	*i*Care	MCW	MHS	MHWI	NHP	UHC
M1	*Availability of services - 42 CFR 438.206*	71.4%	100.0%	100.0%	85.7%	100.0%	85.7%	100.0%
M2	*Timely access to services - 42 CFR 438.206(c)(1)*	100.0%	100.0%	100.0%	85.7%	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*	85.7%	100.0%	100.0%	71.4%	100.0%	71.4%	100.0%
M5	*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%
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*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
M8	*Coverage and authorization of services - 42 CFR 438.210, 42 CFR 440.230, 42 CFR 438.441*	100.0%	100.0%	100.0%	62.5%	100.0%	62.5%	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%	100.0%	100.0%	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)*	75.0%	50.0%	75.0%	75.0%	100.0%	75.0%	100.0%
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%	100.0%
M13	*Provider selection - 42 CFR 438.214*	100.0%	100.0%	90.9%	90.0%	90.9%	90.0%	100.0%

Standard	Citation	BC+ and SSI Managed Care Programs CY2021						
		Anthem	*i*Care	MCW	MHS	MHWI	NHP	UHC
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*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
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+ and SSI Managed Care Programs CY2021						
		Anthem	*i*Care	MCW	MHS	MHWI	NHP	UHC
Q1	*General rules - 42 CFR 438.330(a)*	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%
Q2	*Basic elements of the quality assessment and performance improvement program - 42 CFR 438.330(b)*	100.0%	100.0%	83.3%	83.3%	100.0%	83.3%	100.0%
Q3*	*Performance measurement - 42 CFR 438.330(c)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Q4*	*Performance improvement projects - 42 CFR 438.330(d)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Q5	*QAPI evaluations review - 42 CFR 438.330(e)(2)*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*Q2 and Q3 are evaluated through reviews that occur separate from the Accreditation and Compliance with Standards Reviews

Standard	Citation	BC+ and SSI Managed Care Programs CY2021						
		Anthem	*i*Care	MCW	MHS	MHWI	NHP	UHC
G1	*Grievance systems - 42 CFR 438.228*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
G2	*General requirements- 42 CFR 438.402*	85.7%	100.0%	100.0%	85.7%	100.0%	85.7%	100.0%
G3	*Timely and adequate notice of adverse benefit determination - 42 CFR 438.404*	100.0%	42.9%	100.0%	28.6%	100.0%	28.6%	100.0%
G4	*Handling of grievances and appeals - 42 CFR 438.406*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
G5	*Resolution and notification - 42 CFR 438.408*	100.0%	100.0%	100.0%	76.9%	100.0%	76.9%	100.0%

Standard	Citation	BC+ and SSI Managed Care Programs CY2021						
		Anthem	*i*Care	MCW	MHS	MHWI	NHP	UHC
G6	*Expedited resolution of appeals - 42 CFR 438.410*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
G7	*Information about grievance and appeal system to providers and subcontractors - 42 CFR 438.414*	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
G8	*Record keeping requirements - 42 CFR 438.416*	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
G9	*Continuation of benefits while the local appeal and the State Fair Hearing are pending - 42 CFR 438.420*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
G10	*Effectuation of reversed appeal resolution - 42 CFR 438.424*	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Standard	Citation	BC+ Managed Care Programs CY2021					
		CCHP**	DHP	GHC-SCW	MCHP	Quartz	SHP
M1	*Availability of services - 42 CFR 438.206*	57.1%	71.4%	42.9%	71.4%	85.7%	85.7%
M2	*Timely access to services - 42 CFR 438.206(c)(1)*	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%
M3	*Cultural considerations in services - 42 CFR 438.206(c)(2)*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
M4	*Network adequacy - 42 CFR 438.207*	100.0%	85.7%	85.7%	85.7%	85.7%	71.4%
M5	*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%	83.3%
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%
M7	*Disenrollment: requirements and limitations - 42 CFR 438.56*	80.0%	60.0%	60.0%	100.0%	100.0%	70.0%
M8	*Coverage and authorization of services - 42 CFR 438.210, 42 CFR 440.230, 42 CFR 438.441*	50.0%	100.0%	37.5%	100.0%	75.0%	62.5%
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%
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%	66.7%	100.0%	100.0%

Standard	Citation	BC+ Managed Care Programs CY2021					
		CCHP**	DHP	GHC-SCW	MCHP	Quartz	SHP
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%	75.0%	100.0%	75.0%	100.0%	100.0%
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%
M13	*Provider selection - 42 CFR 438.214*	90.0%	81.8%	90.0%	80.0%	90.9%	90.0%
M14	*Subcontractual relationships and delegation - 42 CFR 438.230*	100.0%	100.0%	100.0%	N/A	100.0%	100.0%
M15	*Practice guidelines - 42 CFR 438.236*	100.0%	100.0%	66.7%	100.0%	100.0%	66.7%
M16*	*Health information systems – 42 CFR 438.242*	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
**Includes results for FCMH

Standard	Citation	BC+ Managed Care Programs CY2021					
		CCHP**	DHP	GHC-SCW	MCHP	Quartz	SHP
Q1	*General rules - 42 CFR 438.330(a)*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Q2	*Basic elements of the quality assessment and performance improvement program - 42 CFR 438.330(b)*	100.0%	100.0%	83.3%	100.0%	100.0%	83.3%
Q3	*Performance measurement - 42 CFR 438.330(c)*	N/A	N/A	N/A	N/A	N/A	N/A
Q4	*Performance improvement projects - 42 CFR 438.330(d)*	N/A	N/A	N/A	N/A	N/A	N/A
Q5	*QAPI evaluations review - 42 CFR 438.330(e)(2)*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*Q2 and Q3 are evaluated through reviews that occur separate from the Accreditation and Compliance with Standards Reviews

Standard	Citation	BC+ Managed Care Programs CY2021					
		CCHP**	DHP	GHC-SCW	MCHP	Quartz	SHP
G1	*Grievance systems - 42 CFR 438.228*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
G2	*General requirements-42 CFR 438.402*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
G3	*Timely and adequate notice of adverse benefit determination - 42 CFR 438.404*	28.6%	57.1%	28.6%	100.0%	100.0%	71.4%
G4	*Handling of grievances and appeals - 42 CFR 438.406*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Standard	Citation	BC+ Managed Care Programs CY2021					
		CCHP**	DHP	GHC-SCW	MCHP	Quartz	SHP
G5	*Resolution and notification - 42 CFR 438.408*	69.2%	92.3%	76.9%	100.0%	100.0%	92.3%
G6	*Expedited resolution of appeals - 42 CFR 438.410*	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%
G7	*Information about grievance and appeal system to providers and subcontractors - 42 CFR 438.414*	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%
G8	*Record keeping requirements - 42 CFR 438.416*	100.0%	50.0%	100.0%	100.0%	100.0%	50.0%
G9	*Continuation of benefits while the local appeal and the State Fair Hearing are pending - 42 CFR 438.420*	100.0%	75.0%	25.0%	100.0%	100.0%	100.0%
G10	*Effectuation of reversed appeal resolution - 42 CFR 438.424*	50.0%	0.0%	100.0%	100.0%	0.0%	100.0%

Standard	Citation	PIHP Managed Care Programs CY2021	
		CCF	WM
M1	*Availability of services - 42 CFR 438.206*	80.0%	80.0%
M2	*Timely access to services - 42 CFR 438.206(c)(1)*	100.0%	100.0%
M3	*Cultural considerations in services - 42 CFR 438.206(c)(2)*	100.0%	100.0%
M4	*Network adequacy - 42 CFR 438.207*	85.7%	100.0%
M5	*Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224*	100.0%	100.0%
M6	*Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224*	80.0%	100.0%
M7	*Disenrollment: requirements and limitations - 42 CFR 438.56*	100.0%	100.0%
M8	*Coverage and authorization of services - 42 CFR 438.210, 42 CFR 440.230, 42 CFR 438.441*	100.0%	100.0%
M9	*Information requirements for all enrollees - 42 CFR 438.100(b)(2)(i), 42 CFR 438.10*	81.8%	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%
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)*	75.0%	100.0%
M12	*Compliance with other federal and state laws - 42 CFR 438.100(d)*	100.0%	100.0%
M13	*Provider selection - 42 CFR 438.214*	70.0%	100.0%

Standard	Citation	PIHP Managed Care Programs CY2021	
		CCF	WM
M14	*Subcontractual relationships and delegation - 42 CFR 438.230*	100.0%	100.0%
M15	*Practice guidelines - 42 CFR 438.236*	100.0%	100.0%
M16*	*Health information systems – 42 CFR 438.242*	N/A	N/A

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

Standard	Citation	PIHP Managed Care Programs CY2021	
		CCF	WM
Q1	*General rules - 42 CFR 438.330(a)*	66.7%	88.9%
Q2	*Basic elements of the quality assessment and performance improvement program - 42 CFR 438.330(b)*	100.0%	100.0%
Q3*	*Performance measurement - 42 CFR 438.330(c)*	N/A	N/A
Q4*	*Performance improvement projects - 42 CFR 438.330(d)*	N/A	N/A
Q5	*QAPI evaluations review - 42 CFR 438.330(e)(2)*	0.0%	0.0%

*Q2 and Q3 are evaluated through reviews that occur separate from the Accreditation and Compliance with Standards Reviews

Standard	Citation	PIHP Managed Care Programs CY2021	
		CCF	WM
G1	*Grievance systems - 42 CFR 438.228*	40.0%	100.0%
G2	*General requirements-42 CFR 438.402*	42.9%	100.0%
G3	*Timely and adequate notice of adverse benefit determination - 42 CFR 438.404*	28.6%	85.7%
G4	*Handling of grievances and appeals - 42 CFR 438.406*	0.0%	100.0%
G5	*Resolution and notification - 42 CFR 438.408*	30.8%	100.0%
G6	*Expedited resolution of appeals - 42 CFR 438.410*	100.0%	66.7%
G7	*Information about grievance and appeal system to providers and subcontractors - 42 CFR 438.414*	0.0%	100.0%
G8	*Record keeping requirements - 42 CFR 438.416*	50.0%	100.0%
G9	*Continuation of benefits while the local appeal and the State Fair Hearing are pending - 42 CFR 438.420*	25.0%	100.0%
G10	*Effectuation of reversed appeal resolution - 42 CFR 438.424*	0.0%	100.0%