External Quality Review

Calendar Year 2022

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

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External Quality Review Organization
MetaStar, Inc. Suite 300 2909 Landmark Place Madison, Wisconsin 53713
Prepared by staff in the External Quality Review Department
Primary Contacts
Jenny Klink, MA, CSW Vice President 608-441-8216 jklink@metastar.com
Andrea Macholl, MS Project Manager 608-441-8222 amacholl@metastar.com
Don Stanislawski, BA Project Coordinator 608-441-8204 dstanisl@metastar.com

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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 & Medicaid Services (CMS) External Quality Review (EQR) Protocols.

This report covers the external quality review calendar year from January 1, 2022 – December 31, 2022 (CY 2022). 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 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: Validation of Performance Improvement Projects

Validation of performance improvement projects is a mandatory review activity, required by 42 CFR 438.358, and is conducted according to federal protocol standards. The purpose of a performance improvement project is to assess and improve processes and outcomes of health care provided by the managed care organization. The validation process determines whether projects have been designed, conducted, and reported in a methodologically sound manner. MetaStar validated the projects conducted by each organization in measurement year 2021.

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 – Compliance with Standards

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

According to 42 CFR 438.360, states have the option to utilize results from a private accreditation review to avoid duplication if the requirements are comparable to standards identified in the EQR protocols and 42 CFR 438.358. Using a crosswalk identifying the requirements evaluated through a compliance with standards review compared to those evaluated through the National Committee for Quality Assurance Health Plan Accreditation, MetaStar identified gaps between the sets of requirements. Managed care organizations submitted the remaining documents, and results are comparable to the 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 Supplemental Security Income 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 was established in 2014 under an Alternative Benefit Plan State Plan Amendment as allowed in federal law under Section 1937 of the Social Security Act (2010). The program is a pre-paid inpatient health plan operated in six counties in southeastern Wisconsin by one managed care organization. The program provides comprehensive and coordinated health care for children in out-of-home care in a way that reflects their unique health needs. Participation in the program is voluntary. All children placed in eligible out-of-home care settings and under the jurisdiction of the child welfare system within the six Wisconsin counties may participate in the program.

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

Appendix A: Information Systems Capabilities Assessment

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

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 their medical, dental, behavioral health, pharmacy, care management, and social service needs.

This review was conducted in CY 2021, Results from this optional activity were reported separately after they were finalized.

Record Review – Obstetrics Medical Home/Healthy Birth Outcomes

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

During CY 22, DHS directed MetaStar to perform data abstraction reviews of its Medical Home initiative for pregnant women. Results from the data abstraction are used by DHS to determine administrative payments to organizations, based on compliance with specific requirements detailed in the DHS contract. Due to the timelines associated with this retrospective review, the results of this optional activity are reported separately.

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 under the state quality strategy section of the 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 1: Validation of Performance Improvement Projects</td></tr>
<tr><td rowspan="2">√</td><td rowspan="2">√</td><td rowspan="2">√</td><td colspan="2">STRENGTHS</td></tr>
<tr><td>Review Findings</td><td>The State Quality Strategy</td></tr>
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Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 1: Validation of Performance Improvement Projects				
			Project topics were selected based on detailed research and its importance to members.	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, and encourage cross-sector partnerships to improve the drivers of health in Wisconsin.
			Projects contained clear, concise, measurable and answerable aim statements.	Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes. Improve member engagement and experience of care.
			Project populations were clearly identified in relation to aim statements.	
			Selected project variables and process measures were clear indicators of performance.	
			Projects documented valid and reliable procedures to collect data and inform its measurements.	
			Organizations selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement.	
			PROGRESS	
			Review Findings	The State Quality Strategy
			Organizations addressed recommendation for interventions to be culturally and linguistically appropriate.	Improve health equity and reduce health disparities through culturally competent practices and policies. Improve member engagement and experience of care.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 1: Validation of Performance Improvement Projects				
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Ensure each project utilizes appropriate techniques to conduct analysis and interpretation of the results, including an assessment of the extent to which any change in performance is statistically significant.	Ensure continuous improvement of high-quality programs to achieve members' identified goals and outcomes.
			Ensure each project conducts repeated measurements using the same methodology and documents if a significant change in performance relative to the baseline occurred.	Ensure continuous improvement of high-quality programs to achieve members identified goals and outcomes.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 2: Validation of Performance Measures Validation				
√	√	√	STRENGTHS	
			Review Findings	The State Quality Strategy
			Timeliness of Prenatal Care.	Provide access to primary care and preventive services to maintain wellbeing, identify health concerns, and ensure timely intervention. Reduce health disparities, improve cultural competence, and encourage cross-sector partnerships to improve the drivers of health in Wisconsin.
			PROGRESS	
			Review Findings	The State Quality Strategy

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 2: Validation of Performance Measures Validation				
			Improvement was demonstrated in the statewide rate since the prior review: Postpartum Care Controlling Blood Pressure Follow up to Emergency Department Visits for Mental Health, Alcohol and Other Drug Abuse or Dependence Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	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.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Facilitate Childhood Immunizations. Improve Postpartum Care. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. Follow up to Emergency Department Visits for Mental Health, Alcohol and Other Drug Abuse or Dependence Follow Up to Hospitalizations for Mental Illness	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.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards				
√	√	√	**STRENGTHS**	
			Review Findings	The State Quality Strategy

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards				
			The organization demonstrated a robust monitoring process that assured network adequacy, as well as the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers.	Reduce health disparities, improve cultural competence, and encourage cross-sector partnerships to improve the drivers of health in Wisconsin. Provide access to primary care and preventive services to maintain wellbeing, identify health concerns, and ensure timely intervention.
			The organization demonstrated the ability to ensure coordination and continuity of member care.	Implement delivery system reform strategies to improve transitions of care.
			The organization has the structure, operations, and processes to ensure an ongoing program of quality assessment and performance improvement.	Ensure continuous improvement of high-quality programs to achieve the members' identified goals and outcomes.
			PROGRESS	
			Review Findings	The State Quality Strategy
			There was no progress identified in this year's review.	Not applicable
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Ensure responsibilities for emergency and post-stabilization of services are defined in the organization's policies and procedures.	Implement delivery system reform strategies to improve transitions of care.
			Update written guidance to include information regarding primary lock-in guidelines	Implement delivery system reform strategies to improve transitions of care.
			Ensure each organization has written policies and procedures for member rights and advance directives, including the right to	Promote and protect the human and legal rights of program beneficiaries. Provide access to primary care and preventive services to maintain

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards				
			participate in decisions regarding care and treatment.	wellbeing, identify health concerns, and ensure timely intervention.
			Update written guidance to include all requirements for issuing *Notices of Adverse Benefit Determination* to the member in the timeframes associated with each type of adverse decision.	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 the organization's appeal and grievance committee composition and structure includes all requirements.	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 organizations have written procedures to comply with all requirements for expedited review process of appeals.	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	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards				
			Ensure organizations comply with requirements for continuation of benefits, duration, and member responsibility for costs.	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.
			When appeal decisions are reversed, ensure services are started or reinstated and payments for those services are made as required.	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	
Protocol 9: Conducting Focused Studies of Health Care Quality, Foster Care Medical Home				
√	√	√	STRENGTHS	
			Review Findings	The State Quality Strategy
			Completion of the Out-of-Home Health Screen.	Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values.
			PROGRESS	
			Review Findings	The State Quality Strategy
			No progress was identified based on recommendations from the prior review.	Not applicable

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 9: Conducting Focused Studies of Health Care Quality, Foster Care Medical Home				
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Ensure the initial care plan is developed with all required individuals' input within the first 60 days of enrollment.	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.
			Focus on developing comprehensive care plans.	
			Prioritize follow-up for identified needs during the initial health assessment and on an ongoing basis.	
			Develop transition plans prior to program disenrollment.	
			Ensure transition plans are comprehensive.	

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Appendix A: Information Systems Capabilities Assessments				
√	√	√	STRENGTHS	
			Review Findings	The State Quality Strategy
			Strong systems were maintained and updated by stable and experienced information system departments.	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,

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Appendix A: Information Systems Capabilities Assessments				
				and effectively in achieving desired outcomes.
			Robust and ongoing training was in place to ensure all Medicaid data is processed accurately and within the expected timeframes.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.
			Security systems met or exceed most industry standards, ensuring consistent system and data availability.	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.
			Processes and systems for collecting and maintaining administrative data and enrollment information ensured accurate encounter data is provided to the state.	
			PROGRESS	
			Review Findings	The State Quality Strategy
			Improved the ability to obtain segment breakdowns of paper versus electronic claims and continued to encourage providers to transition to electronic submission of claims.	Ensure timely access to complete and accurate health data.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Continue to monitor claims from a third-party vendor to ensure completeness of data in the encounter submission files.	Ensure timely access to complete and accurate health data. Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. Evaluate data systems to ensure they effectively support programs and strategies in collecting
			Continue collaborative efforts between the information technology and claims department to increase the claims auto-adjudication rate.	

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Appendix A: Information Systems Capabilities Assessments				
			Explore the possibility of consolidating the number of systems the organization uses to manage claims processing, in order to improve efficiencies.	relevant and adequate clinical and other data from multiple sources.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Non-Managed Care Programs – Children with Medical Complexities				
√	√	√	STRENGTHS	
			Review Findings	The State Quality Strategy
			The organizations had processes in place to ensure that members met program eligibility requirements.	Not applicable
			When applicable, records contained evidence of voluntary consent for program participation.	
			Assessments of members' medical, social, and education needs were comprehensive and completed timely.	
			Care plans were completed timely.	
			Member-specific medical, social, and educational needs were addressed and documented in the record.	
			Coordination of and follow-up on referrals was completed as required.	
			PROGRESS	
			Review Findings	The State Quality Strategy

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Non-Managed Care Programs – Children with Medical Complexities				
			Assessments of members' needs were comprehensive.	Not applicable
			Care plans were comprehensive	
			RECOMMENDATIONS	
			Review Findings	Review Findings
			Ensure comprehensive care plans, which include goals, activities to meet goals, and timelines for activities.	Not applicable
			Obtain mutual agreement prior to making care plan changes.	
			Ensure follow-up with family within three days of inpatient hospitalization.	

Introduction and Overview

Acronyms and Abbreviations

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

Purpose of the Report

This is the annual technical report that the State of Wisconsin must provide to the Centers for Medicare & Medicaid Services (CMS) related to the operation of its Medicaid managed health 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 non-managed care programs, the State of Wisconsin has requested record review for the following programs: OB Medical 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, 2022-December 31, 2022 (CY 2022). 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 BC+, SSI, FCMH, WM, and CCF Organizations

As of December 2022, enrollment was as follows:

Program	Enrollment
BadgerCare Plus	1,070,788
Supplemental Security Income Medicaid	62,293
Prepaid Inpatient Health Plans	821
Foster Care Medical Home	2,905

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, including 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)	National Committee for Quality Assurance (NCQA) Medicaid Accreditation with Multicultural Health Care Distinction Expires: 10/11/2024
Children's Community Health Plan, Inc. (CCHP)	BC+	NCQA Medicaid Accreditation Expires: 12/18/2023 Exchange Accreditation Expires: 12/18/2023
Dean Health Plan, Inc. (DHP)	BC+	NCQA Medicare and Commercial Accreditation Expires: 3/14/2025
Group Health Cooperative of Eau Claire (GHC-EC)	BC+ SSI	Not Accredited
Group Health Cooperative of South-Central Wisconsin (GHC-SCW)	BC+	NCQA Commercial and Exchange Accreditation Expires: 7/19/2025
Independent Care Health Plan (*i*Care)	BC+ SSI	Not Accredited
MercyCare Health Plans (MCHP)	BC+	NCQA Commercial Accreditation Expired:8/5/2022 This organization is not currently accredited.
MHS Health Wisconsin (MHS)	BC+ SSI	NCQA Medicaid Accreditation Expires: 8/12/2025
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 Expires: Unknown
Quartz Health Solutions, Inc. (Quartz)	BC+	NCQA Medicare and Commercial Accreditation Expires: 5/17/2024
Security Health Plan (SHP)	BC+ SSI	NCQA Medicaid Accreditation Expires: 5/8/2023
United Healthcare Community Plan (UHC)	BC+ SSI	NCQA Medicare and Commercial Accreditation

Managed Care Organization	Program(s)	Accreditation Organization and Status
		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
Foster Care Medical Home (FCMH)	This program serves children in out-of-home care.	Not Accredited
Wraparound Milwaukee (WM)	This program serves children with mental health needs	Not Accredited

Hospital	Program(s)	Accreditation Organization and Status
Children's Hospital of Wisconsin (CHW)	CMC	Not Accredited
Marshfield Children's Hospital (MCH)	CMC	Not Accredited
UW Health American Family Children's Hospital (AFCH)	CMC	Not Accredited

CMC is a benefit program separate from the managed care programs and enrollment numbers are not publicly reported.

Analysis: Quality, Timeliness, 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 PIHPs included in this report do not provide long-term services and supports. Compliance with these review activities provides assurances the 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 operates.

Anthem	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 154,126 SSI: 8,334
Findings	
Protocol 1: Validation of Performance Improvement Projects (PIPs)	**Strengths** - The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. - The organization established a clear, concise, measurable and answerable aim statement for both projects.

Anthem	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 154,126 SSI: 8,334
Findings	
• *Reducing Health Disparities in Postpartum Care* • *Reducing Surgery Related Opioid Prescriptions*	- The organization clearly identified the PIP population in relation to the aim statement for both projects. - The organization selected PIP variables and performance measures that were clear indicators of performance for one project. - The organization used valid and reliable procedures to collect the PIP data and inform its measurements for one project. - The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. **Progress** - The projects included all eligible members in the study population. - The projects included a data analysis plan that included the frequency of data collection and analysis. - The MCO completed their data analysis in accordance with their data analysis plan. - The projects utilized Plan-Do-Study-Act cycles to assess success of the interventions. - The projects addressed cultural and linguistic appropriateness of the interventions. **Recommendations** - Include evidence of statistical analysis to assess differences between the initial and repeat measurements. - Include statistical evidence that observed improvement is the result of the interventions. - Ensure sustained improvement is demonstrated through repeated measurements over time for continuing projects.
Protocol 2: Validation of Performance Measures	**Strengths** – Childhood Immunizations. – Postpartum Care. – Timeliness of Prenatal Care. – Controlling Blood Pressure. – Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. – Follow-Up After Hospitalization for Mental Illness. – Follow-Up after Emergency Department Visit for Mental Illness. **Progress** – Improved Timeliness of Prenatal Care. – Increased Controlling Blood Pressure rates. – Ensured Follow-Up after Emergency Department Visit for Mental Illness. – Improved Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. **Recommendations** – Improve the rate of Adolescent Immunizations. – Increase Lead Screening in Children.

Anthem	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 154,126 SSI: 8,334
Findings	
	– Ensure Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	Not applicable. The Accreditation Desk Review was conducted in CY 2021.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	Following the FY 20-21 care management review, the review was paused for FY 21-22 at the request of DHS in order to realign review criteria with the DHS-MCO contract.
Appendix A: Information Systems Capabilities Assessments (ISCA)	The ISCA review was not conducted for NCQA accredited organizations in CY 2022. MetaStar and DHS are working towards scheduling the ISCA review, which will be reported on in future Annual Technical Reports.
Conducting Focused Studies of Health Care Quality *OBMH Record Review*	The results of the OBMH review are reported separately.

CCHP	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, FCMH	BC+: 156,191 FCMH: 2,905
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Reducing Health Disparities in Postpartum Care* • *Improving Completed Dilated Retinal Diabetic Exams Rates*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for one project. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. **Progress** – The projects clearly described how all data was collected. – Interventions were modified and enhanced from the prior year when performance was less than optimal for both of the continuing projects.

CCHP	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, FCMH	BC+: 156,191 FCMH: 2,905
Findings	
	Recommendations – Ensure the aim statement is measurable and reflects an improvement from the identified baseline measurement. – Include evidence of statistical analysis to assess differences between initial and repeat measures. – Ensure analysis focuses on identifying and accounting for any factors that may influence the comparability of initial and repeat measures. – Perform and document an analysis comparing the PIP results to other entities or population subgroups. – Ensure the PIP report specifies how improvement strategies are culturally and linguistically appropriate. – Continue to build methodologically sound PIPs to ensure project results demonstrate an improvement from the actual baseline measurement each year of a continuing project. – Ensure the initial baseline measure is consistently identified for each year of a continuing project.
Protocol 2: Validation of Performance Measures	**Strengths** - Immunizations for Adolescents. - Postpartum Care. **Progress** - Improved Immunizations for Adolescents. **Recommendations** – Increase Childhood Immunizations. – Ensure Lead Screening in Children. – Improve Timeliness of Prenatal Care.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	Not applicable. The Accreditation Desk Review was conducted in CY 2021.
Protocol 9: Conducting Focused Studies of Health Care Quality *C4K FCMH Care Management Review* *Sample Size: 55*	**Strengths** - Completion of the Out-of-Home Health Screen. **Progress** - No progress was identified based on recommendations from the prior review. **Recommendations** - Ensure the initial care plan is developed with all required individual's input within the first 60 days of enrollment. - Focus on developing comprehensive care plans. - Prioritize follow-up for identified needs during the initial health assessment and on an ongoing basis. - Develop transition plans prior to program disenrollment. - Ensure transition plans are comprehensive.

CCHP	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, FCMH	BC+: 156,191 FCMH: 2,905
Findings	
Appendix A: Information Systems Capabilities Assessments	The ISCA review was not conducted for NCQA accredited organizations in CY 2022. MetaStar and DHS are working towards scheduling the ISCA review, which will be reported on in future Annual Technical Reports.
Conducting Focused Studies of Health Care Quality *OBMH Record Review*	The results of the OBMH review are reported separately.

DHP	
Programs Operated	**CY 2022 Enrollment by Program**
BC+	BC+: 51,397
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Reducing Health Disparities in Postpartum Care* • *Increasing Adolescent Immunization Rates*	**Strengths** - The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. - The organization established a clear, concise, measurable and answerable aim statement for both projects. - The organization clearly identified the PIP population in relation to the aim statement for both projects. - The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. - The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. - The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. **Progress** – Both projects defined the sources of data related to interventions that occurred during the project. – The PIP reports included initial and repeat measures, and identified project limitations. – The data was analyzed as planned for both projects. – The projects demonstrated the use of Plan-Do-Study-Act cycles during the projects. **Recommendations** – Include evidence of statistical analysis to assess differences between the initial and repeat measurements. – Include evidence of statistical tests to determine if any observed improvement is the result of the interventions. – Ensure the project is methodologically sound to increase the probability of demonstrating performance improvement from the baseline to the final rate for projects. –
Protocol 2: Validation of Performance Measures	**Strengths** – Childhood Immunizations. – Timeliness of Prenatal Care. – Postpartum Care.

DHP	
Programs Operated	**CY 2022 Enrollment by Program**
BC+	BC+: 51,397
Findings	
	Progress – Increased Timeliness of Prenatal Care. – Improved Postpartum Care. **Recommendations** – Improve Adolescent Immunizations. – Increase Lead Screening in Children.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	Not applicable. The Accreditation Desk Review was conducted in CY 2021.
Appendix A: Information Systems Capabilities Assessments	The ISCA review was not conducted for NCQA accredited organizations in CY 2022. MetaStar and DHS are working towards scheduling the ISCA review, which will be reported on in future Annual Technical Reports.
Conducting Focused Studies of Health Care Quality *OBMH Record Review*	The results of the OBMH review are reported separately.

GHC-EC	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 57,488 SSI: 3,433
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Reducing Health Disparities in Postpartum Care* • *Improving Mental Health Hospitalization Follow-Up Rates*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable, and answerable aim statement for one project. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. **Progress** – Both projects defined the data sources and data collection tools for all measures.

GHC-EC	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 57,488 SSI: 3,433
Findings	
	– Staff responsible for collecting medical review data were identified, along with their qualifications. – Data analysis in both projects demonstrated the ongoing exploration for less than optimal performance. – The projects identified the effectiveness of each intervention. **Recommendations** – Ensure the aim statement includes a goal for improvement. – Include evidence of statistical analysis to assess differences between the initial and repeat measures. – Include statistical analysis to assess if improvements were the result of the interventions. – Focus efforts on improving results of repeat measurements each year of the project.
Protocol 2: Validation of Performance Measures	**Strengths** – Childhood Immunizations. – Immunizations for Adolescents. – Timeliness of Prenatal Care. – Postpartum Care. – Controlling Blood Pressure. – Follow-Up After Hospitalization for Mental Illness. – Follow-Up after Emergency Department Visit for Mental Illness. **Progress** – Increased Childhood Immunizations. – Improved Adolescent Immunizations. – Increased Timeliness of Prenatal Care. – Increased Controlling Blood Pressure. **Recommendations** – Improve Lead Screening in Children. – Ensure Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. – Increase Initiation and Engagement of Alcohol and Other Drug Abuse or 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. – The organization demonstrated a robust monitoring process to ensure the provider network is adequate.

GHC-EC	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 57,488 SSI: 3,433
Findings	
	Progress – Results from the compliance with standards review are not comparable to prior years; therefore, no progress can be reported on from the previous review. **Recommendations** – Ensure responsibilities for emergency and post-stabilization of services are defined in the organization's policies and procedures. – Update written guidance to reflect that members are notified within 15 days after receipt or issuance of the contracted provider's termination notice. – Ensure all required elements are included in the provider directory for all services offered. – Update guidance to include information regarding the primary lock-in guidelines. – Revise the MCO's process to give the member rights policy to providers as required. – Develop and implement a restraint policy. – Revise the MCO's *Advance Directives* policy to include all required information. – Implement a formal process of peer review of care delivered by providers that includes the active participation of contracted providers and documents the findings. – Ensure implementation of the provider preventable conditions as a condition of payment, as well as the prohibition of payment for provider-preventable conditions. These criteria were included in a policy submitted; however, the policy was not in effect during the review period. – Include the MCO Advocate as a member of the grievance and appeal committee. – Update written guidance to include all requirements for issuing notices to the member in the timeframes associated with each type of adverse decision. – Ensure the committee composition and structure includes all requirements. – Revise the policy regarding appeal extensions to include the two calendar day timeframe for notifying members of the extension and update the extension letter to include information regarding the member's right to file a grievance if they disagree with the extension. – Update the *Grievance and Appeal Process* policy to include the timeframe to provide all relevant materials to the appropriate party (the Department, the state's fiscal agent, or the Division of Hearings and Appeals) within five business days, or sooner if possible when requested. – Update written guidance to include punitive action is not taken against anyone who requests an expedited resolution or supports a member's appeal. – Develop and implement a process to notify members in writing of the decision to deny a request for an expedited resolution of an appeal. – Distribute the *Ombudsmen Brochure* and *HMO and PIHP Grievances and Appeals Guide* to providers at the time the contract is entered. – Update written guidance to include the criteria for continuing and for ending benefits during an appeal.

GHC-EC	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 57,488 SSI: 3,433
Findings	
	– Update written guidance to include the requirements for the effectuation of reversed appeal decisions.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	Following the FY 20-21 care management review, the review was paused for FY 21-22 at the request of DHS in order to realign review criteria with the DHS-MCO contract.
Appendix A: Information Systems Capabilities Assessments	**Strengths** – The organization has a strong system that is maintained and updated by a stable and experienced information system department. – The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes. – The organization's security systems meet or exceed most industry standards, ensuring consistent system and data availability. – The organization's processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter data is provided to the state. **Progress** – The MCO focused efforts on addressing the opportunity for improvement from the prior ISCA. **Recommendations** – Continue collaborative efforts between the information technology and claims department to increase the claims auto-adjudication rate. This recommendation was identified in the prior ISCA.

GHC-SCW	
Programs Operated	**CY 2022 Enrollment by Program**
BC+	BC+: 8,340
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Reducing Health Disparities in Postpartum Care* • *Improving Childhood Immunization Rates*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects.

GHC-SCW	
Programs Operated	**CY 2022 Enrollment by Program**
BC+	BC+: 8,340
Findings	
	Progress – The organization demonstrated sustained improvement for the multi-year project. **Recommendations** – Include evidence of statistical analysis to assess differences between the initial and repeat measurements. – Continue to build methodologically sound PIPs to demonstrate improvement from baseline to remeasurement. – Include evidence of statistical tests to determine if any observed improvement is the result of the interventions.
Protocol 2: Validation of Performance Measures	**Strengths** – Immunizations for Adolescents. – Timeliness of Prenatal Care. – Postpartum Care. **Progress** – Increased Immunization for Adolescents. – Improved Timeliness of Prenatal Care. **Recommendations** – Increase Childhood Immunization. – Improve Lead Screening in Children.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	Not applicable. The Accreditation Desk Review was conducted in CY 2021.
Appendix A: Information Systems Capabilities Assessments	The ISCA review was not conducted for NCQA accredited organizations in CY 2022. MetaStar and DHS are working towards scheduling the ISCA review, which will be reported on in future Annual Technical Reports.
Conducting Focused Studies of Health Care Quality *OBMH Record Review*	The results of the OBMH review are reported separately.

*i*Care	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 33,298 SSI: 10,888
Findings	
Protocol 1: Validation of Performance Improvement Projects	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for both projects.

*i*Care	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 33,298 SSI: 10,888
Findings	
• *Reducing Health Disparities in Postpartum Care* • *Reducing Health Disparities in Controlling High Blood Pressure*	– The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization established valid and reliable methods for data collection for one project. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. **Progress** – The projects submitted included the goal for the study question. – The population was clearly defined with inclusion and exclusion criteria in both projects. – The projects defined measurable indicators, including numerators and denominators, to measure change in the desired outcome. – Both projects addressed cultural or linguistic appropriateness of the member-facing interventions. **Recommendations** – Include all data sources in the data collection procedures. – Establish a data collection plan that links to the data analysis plan by ensuring that appropriate data is available. – Complete the data analysis according to the data analysis plan or explain why there was deviation from the plan when warranted. – Include evidence of statistical analysis to assess differences between the initial and repeat measurements. – Account for factors that may influence the comparability of initial and repeat measures. – Account for factors that may threaten the internal or external validity of the findings. – Present PIP findings in an easily understood manner. – Include lessons learned for less-than-optimal performance. – Include how the improvement strategy is designed to address root causes or barriers identified through data analysis and quality improvement processes. – Describe how Plan, Do, Study, Act cycles were utilized. – Utilize the same methodology for baseline and repeat measurements. – Build a methodologically sound PIP to ensure project results demonstrate an improvement from the baseline rates for all projects.
Protocol 2: Validation of Performance Measures	**Strengths** – Postpartum Care. – Controlling Blood Pressure. – 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 or Dependence Treatment.

*i*Care	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 33,298 SSI: 10,888
Findings	
	– Follow-Up after Emergency Department Visit for Mental Illness. **Progress** – Improved Controlling Blood Pressure. – Ensured Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. – Improved Follow-Up After Hospitalization for Mental Illness. – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. – Improved Follow-Up after Emergency Department Visit for Mental Illness. **Recommendations** – Increase Childhood Immunizations. – Improve Immunizations for Adolescents. – Ensure Lead Screening for Children. – Improve Timeliness of Prenatal Care.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	Not applicable. *i*Care's last Compliance with Standards Review was conducted in CY 2021.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	Following the FY 20-21 care management review, the review was paused for FY 21-22 at the request of DHS in order to realign review criteria with the DHS-MCO contract.
Appendix A: Information Systems Capabilities Assessments	**Strengths** – The organization has a strong system that is maintained and updated by a stable and experienced information system department. – The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes. – The organization's security systems meet or exceed most industry standards, ensuring consistent system and data availability. – The organization's processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter data is provided to the state. **Progress** – The organization improved its ability to obtain segment breakdowns of paper versus electronic claims and continues to encourage providers to transition to electronic submission of claims. **Recommendations** – Continue to monitor claims from the third-party vision vendor to ensure completeness of data in the encounter submission files.

*i*Care	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 33,298 SSI: 10,888
Findings	
Conducting Focused Studies of Health Care Quality *OBMH Record Review*	The results of the OBMH review are reported separately.

MCHP	
Programs Operated	**CY 2022 Enrollment by Program**
BC+	BC+: 16,833
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Reducing Health Disparities in Postpartum Care* • *Improving Lead Screening Rates in Children*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for one project. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. **Progress** – Both projects specified a data analysis plan. – Both projects used evidenced-based improvement strategies. – Both projects were culturally and linguistically appropriate. **Recommendations** – Ensure the variables measure the PIP aim statement. – Ensure the data analysis is completed according to the data analysis plan. – Include evidence of statistical analysis to assess differences between initial and repeat measures. – Include an analysis of factors that may influence the comparability of initial and repeat measures. – Use a rapid-cycle Plan, Do, Study, Act approach to test the selected improvement strategies during the project. – Continue efforts to build a methodologically sound PIP to ensure project results demonstrate an improvement from the baseline rate. – Focus efforts on improving results of repeat measurements each year of a continuing project.
Protocol 2: Validation of Performance Measures	**Strengths** – Childhood Immunizations.

MCHP	
Programs Operated	**CY 2022 Enrollment by Program**
BC+	BC+: 16,833
Findings	
	Progress – There is no progress to report. **Recommendations** – Increase Immunizations for Adolescents. – Improve Lead Screening for Children. – Ensure Prenatal Care. – Increase Postpartum Care.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	Not applicable. The Accreditation Desk Review was conducted in CY 2021.
Appendix A: Information Systems Capabilities Assessments	The ISCA review was not conducted for NCQA accredited organizations in CY 2022. MetaStar and DHS are working towards scheduling the ISCA review, which will be reported on in future Annual Technical Reports.
Conducting Focused Studies of Health Care Quality *OBMH Record Review*	The results of the OBMH review are reported separately.

MHS	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 60,985 SSI: 7,153
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Reducing Health Disparities in Postpartum Care* • *Improving Pharmacotherapy Management of Asthma/Chronic Obstructive Pulmonary Disease*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. **Progress** – No progress was identified in the validation of the projects, and recommendations from the prior review were not successfully addressed in each project submitted.

MHS	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 60,985 SSI: 7,153
Findings	
	Recommendations – Include analysis of statistical significance of any differences between baseline and repeat measurements. – Write PIP findings in a clear and understandable manner. – Develop and implement a process to ensure a consistent methodology for both the baseline and repeat measurement. – Conduct methodologically sound projects to increase the probability of demonstrating improvement through the PIP process – Utilize consistent methodology to demonstrate methodologically sound improvement due to PIP interventions. – Include statistical analysis of improvements. – Utilize consistent methodology to demonstrate sustained improvement over time.
Protocol 2: Validation of Performance Measures	**Strengths** – Controlling Blood Pressure. – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. – Follow-Up after Emergency Department Visit for Mental Illness. **Progress** – There is no progress to report. **Recommendations** – Increase Childhood Immunizations. – Improve Immunizations for Adolescents. – Ensure Lead Screening for Children. – Improve Timeliness of Prenatal Care. – Increase Postpartum Care. – Follow-Up After Hospitalization for Mental Illness. – Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	Not applicable. The Accreditation Desk Review was conducted in CY 2021.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	Following the FY 20-21 care management review, the review was paused for FY 21-22 at the request of DHS in order to realign review criteria with the DHS-MCO contract.
Appendix A: Information Systems Capabilities Assessments	The ISCA review was not conducted for NCQA accredited organizations in CY 2022. MetaStar and DHS are working towards scheduling the ISCA review, which will be reported on in future Annual Technical Reports.

MHS	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 60,985 SSI: 7,153
Findings	
Protocol 9: Conducting Focused Studies of Health Care Quality *OBMH Record Review*	The results of the OBMH review are reported separately.

MHWI	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 71,296 SSI: 3,490
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Reducing Health Disparities in Postpartum Care* • *Improving Controlling High Blood Pressure Rates*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. **Progress** – The organization included a list of staff responsible for medical record review data collection and their credentials. – The organization conducted analysis of the data to determine reasons for less than optimal performance. **Recommendations** – Include evidence of statistical analysis to assess differences between initial and repeat measures. – Continue efforts to build a methodologically sound PIP to ensure project results demonstrate an improvement from the baseline rate. Continue efforts on improving results of repeat measurements each year of a continuing project.
Protocol 2: Validation of Performance Measures	**Strengths** – Immunizations for Adolescents. – Controlling Blood Pressure. – Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. – Follow-Up After Hospitalization for Mental Illness. **Progress** – Increased Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence.

MHWI	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 71,296 SSI: 3,490
Findings	
	– Improved Follow-Up After Hospitalization for Mental Illness. **Recommendations** – Ensure Childhood Immunizations. – Improve Lead Screening in Children. – Increase Timeliness of Prenatal Care. – Improve Postpartum Care. – Follow-Up after Emergency Department Visit for Mental Illness. – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	Not applicable. The Accreditation Desk Review was conducted in CY 2021.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	Following the FY 20-21 care management review, the review was paused for FY 21-22 at the request of DHS in order to realign review criteria with the DHS-MCO contract.
Appendix A: Information Systems Capabilities Assessments	The ISCA review was not conducted for NCQA accredited organizations in CY 2022. MetaStar and DHS are working towards scheduling the ISCA review, which will be reported on in future Annual Technical Reports.
Conducting Focused Studies of Health Care Quality *OBMH Record Review*	The results of the OBMH review are reported separately.

MCW	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 24,355 SSI: 3,295
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Reducing Health Disparities in Postpartum Care* • *Improving Adolescent Immunizations Rates*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for all projects. – The organization established a clear, concise, measurable, and answerable aim statement for one project. – The organization clearly identified the PIP population in relation to the aim statement for all projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for all projects.

MCW	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 24,355 SSI: 3,295
Findings	
	– The organization used valid and reliable procedures to collect the PIP data and inform its measurements for all projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for three projects. **Progress** – No progress was identified in the validation of the projects, and recommendations from the prior review were not successfully addressed in each project submitted. **Recommendations** – Ensure aim statements include all required criteria. – Include evidence of statistical analysis to assess differences between the initial and repeat measurements. – Compare project results to more than the baseline, such as patient subgroups, provider sites, or organizations. – Include lessons learned about less-than-optimal performance of PIP results. – Include a strategy that is designed to account or adjust for any major confounding variables that could have an impact on PIP outcomes. – Using data analysis and interpretation, assess the extent to which the improvement strategy was successful and identify potential follow-up activities. – Ensure the same methodology is utilized to calculate the baseline and repeat measurements by identifying the method of calculation. – Build a methodologically sound PIP to ensure project results demonstrate an improvement from the baseline rates for all projects.
Protocol 2: Validation of Performance Measures	**Strengths** – Follow-Up After Hospitalization for Mental Illness. **Progress** – Improved Follow-Up After Hospitalization for Mental Illness. **Recommendations** – Increase Childhood Immunizations. – Improve Immunizations for Adolescents. – Ensure Lead Screening for Children. – Improve Timeliness of Prenatal Care. – Increase Postpartum Care. – Improve 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 or Dependence Treatment. – Follow-Up after Emergency Department Visit for Mental Illness.

MCW	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 24,355 SSI: 3,295
Findings	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	Not applicable. Compliance with Standards Reviews were conducted in CY 2021 for Trilogy and Care Wisconsin, the two legacy organizations that merged to form MCW.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	Following the FY 20-21 care management review, the review was paused for FY 21-22 at the request of DHS in order to realign review criteria with the DHS-MCO contract.
Appendix A: Information Systems Capabilities Assessments	**Strengths** – The organization has a strong system that is maintained and updated by a stable and experienced information system department. – The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes. – The organization's security systems meet or exceed most industry standards, ensuring consistent system and data availability. – The organization's processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter data is provided to the state. **Progress** – The organization was newly formed in January 2020. The evaluation conducted in CY 2022 is the first evaluation conducted for the MCO. **Recommendations** – Explore the possibility of consolidating the number of systems the MCO uses to manage claims processing, in order to improve efficiencies.
Conducting Focused Studies of Health Care Quality *OBMH Record Review*	The results of the OBMH review are reported separately.

NHP	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 59,912 SSI: 4,761
Findings	
Protocol 1: Validation of Performance Improvement Projects	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for one project.

NHP	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 59,912 SSI: 4,761
Findings	
• *Reducing Health Disparities in Postpartum Care* • *Reducing Health Disparities Reduction in Asthma/COPD*	– The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. **Progress** – The prior review did not identify any recommendations that the organization needed to address. **Recommendations** – Ensure the aim of the project is a measurable improvement goal. – Include evidence of statistical analysis to assess differences between the initial and repeat measures. – Ensure that information contained in the narrative corresponds with information presented in the tables. – Include statistical evidence that demonstrates project improvement was a result of the interventions. – Ensure improvement is achieved for all measures in the project.
Protocol 2: Validation of Performance Measures	**Strengths** – Postpartum Care. – Controlling Blood Pressure. – Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence. – Follow-Up After Hospitalization for Mental Illness. – Follow-Up after Emergency Department Visit for Mental Illness. **Progress** – Increased Postpartum Care. – Improved Controlling Blood Pressure. – Follow-Up After Hospitalization for Mental Illness. **Recommendations** – Increase Childhood Immunizations. – Improve Immunizations for Adolescents. – Ensure Lead Screening for Children. – Increase Timeliness of Prenatal Care. – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.

NHP	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 59,912 SSI: 4,761
Findings	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	Not applicable. The Accreditation Desk Review was conducted in CY 2021.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	Following the FY 20-21 care management review, the review was paused for FY 21-22 at the request of DHS in order to realign review criteria with the DHS-MCO contract.
Appendix A: Information Systems Capabilities Assessments	The ISCA review was not conducted for NCQA accredited organizations in CY 2022. MetaStar and DHS are working towards scheduling the ISCA review, which will be reported on in future Annual Technical Reports.
Protocol 9: Conducting Focused Studies of Health Care Quality *OBMH Record Review*	The results of the OBMH review are reported separately.

Quartz	
Programs Operated	**CY 2022 Enrollment by Program**
BC+	BC+: 54,741
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Reducing Health Disparities in Postpartum Care* • *Improving the Lead Screening Rates in Children*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. **Progress** – Both projects described how interventions were selected. **Recommendations** – Ensure personnel and relevant qualifications are outlined for all staff completing medical record review. – Ensure the data analysis is conducted in accordance with the data analysis plan.

Quartz	
Programs Operated	**CY 2022 Enrollment by Program**
BC+	BC+: 54,741
Findings	
	– Include evidence of statistical analysis to assess differences between the initial and repeat measurements. – Include a rapid-cycle Plan, Do, Study, Act approach to test selected improvement strategies. – Ensure the same methodology is utilized to calculate the baseline and repeat measurements. – Continue to build methodologically sound PIPs to ensure project results demonstrate an improvement from the baseline rates for both projects. – Focus efforts on improving results of repeat measurements each year of the project. – Include evidence of all data collection and analysis in the PIP report.
Protocol 2: Validation of Performance Measures	**Strengths** – Childhood Immunizations. – Immunizations for Adolescents. – Postpartum Care. **Progress** – Increased Immunizations for Adolescents. – Ensure Postpartum Care. **Recommendations** – Ensure Lead Screening for Children. – Increase Timeliness of Prenatal Care.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	Not applicable. The Accreditation Desk Review was conducted in CY 2021.
Appendix A: Information Systems Capabilities Assessments	The ISCA review was not conducted for NCQA accredited organizations in CY 2022. MetaStar and DHS are working towards scheduling the ISCA review, which will be reported on in future Annual Technical Reports.
Conducting Focused Studies of Health Care Quality *OBMH Record Review*	The results of the OBMH review are reported separately.

SHP	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 78,261 SSI: 322
Findings	
Protocol 1: Validation of Performance Improvement Projects	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for one project.

SHP	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 78,261 SSI: 322
Findings	
• *Reducing Health Disparities in Postpartum Care* • *Improving the Lead Screening Rates in Children*	– The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. **Progress** – The organization included a data analysis plan in both projects. – The organization addressed root causes or barriers identified through data analysis to develop new interventions. **Recommendations** – Ensure the aim of the project includes a measurable improvement goal. – Include evidence of statistical analysis to assess differences between the initial and repeat measures. – Ensure findings are presented in a concise and easily understood manner in future reports, including accurate labels on all figures and tables to ensure clarity of baseline and repeat measurements. – Build a methodologically sound PIP to ensure future project results demonstrate an improvement from the baseline rate.
Protocol 2: Validation of Performance Measures	**Strengths** – Childhood Immunizations. – Immunizations for Adolescents. **Progress** – There is no progress to report. **Recommendations** – Ensure Lead Screening for Children. – Improve Timeliness of Prenatal Care. – Increase Postpartum Care.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	Not applicable. The Accreditation Desk Review was conducted in CY 2021.
Appendix A: Information Systems Capabilities Assessments	The ISCA review was not conducted for NCQA accredited organizations in CY 2022. MetaStar and DHS are working towards scheduling the ISCA review, which will be reported on in future Annual Technical Reports.

UHC	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 243,565 SSI: 20,617
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Reducing Health Disparities in Postpartum Care* • *Improving Controlling High Blood Pressure Rates*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the PIP data and interpret the results for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. – The organization demonstrated statistically significant improvement that may be the result of its selected interventions for one project. **Progress** – The projects identified the staff, their qualifications and training for completing medical record review. **Recommendations** – Focus efforts on improving results of repeat measurements each year of a continuing project.
Protocol 2: Validation of Performance Measures	**Strengths** – Childhood Immunizations. – Timeliness of Prenatal Care. – Postpartum Care. – Follow-Up after Emergency Department Visit for Mental Illness. **Progress** – Improved Timeliness of Prenatal Care. – Increased Postpartum Care. **Recommendations** – Ensure Immunizations for Adolescents. – Improve Lead Screening for Children. – Improve Controlling Blood Pressure. – 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 or Dependence Treatment.

UHC	
Programs Operated	**CY 2022 Enrollment by Program**
BC+, SSI	BC+: 243,565 SSI: 20,617
Findings	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	Not applicable. The Accreditation Desk Review was conducted in CY 2021.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	Following the FY 20-21 care management review, the review was paused for FY 21-22 at the request of DHS in order to realign review criteria with the DHS-MCO contract.
Appendix A: Information Systems Capabilities Assessments	The ISCA review was not conducted for NCQA accredited organizations in CY 2022. MetaStar and DHS are working towards scheduling the ISCA review, which will be reported on in future Annual Technical Reports.
Conducting Focused Studies of Health Care Quality *OBMH Record Review*	The results of the OBMH review are reported separately.

CCF	
Programs Operated	**CY 2022 Enrollment by Program**
Children Come First	80
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Increasing the use of Family-Based Services*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for the project. – The organization clearly identified the PIP population in relation to the aim statement for the project. – The organization selected PIP variables and performance measures that were clear indicators of performance for the project. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for the project. **Progress** – The PIP used defined and measurable variables to adequately address the aim statement. – The performance measures enabled the organization to monitor results of the project during the measurement year. – The data analysis plan was specified in the PIP report. – The PIP project specified a repeat measure. – The PIP results and findings were presented in a concise and easily understood manner.

CCF	
Programs Operated	**CY 2022 Enrollment by Program**
Children Come First	80
Findings	
	Recommendations – Ensure the aim statement clearly specifies the project's start and end measurement period to ensure the project's study question is answerable. – Ensure the project's analysis is conducted in accordance with the data analysis plan. – Compare project results to at least one other entity or subgroup within the organization. – Include a rapid-cycle Plan-Do-Study-Act approach to evaluate improvement strategies. – Continue to build a methodologically sound PIP to ensure project results demonstrate an improvement from the baseline rates for each study question or aim statement.
Protocol 2: Validation of Performance Measures	There are no measures to report. DHS is currently working to develop measures.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	Not applicable. CCF's last Compliance with Standards Review was conducted in CY 2021.
Appendix A: Information Systems Capabilities Assessments	Not applicable. CCF's last ISCA was conducted in CY 2021.

WM	
Programs Operated	**CY 2022 Enrollment by Program**
Wraparound Milwaukee	741
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Increasing Youth Engagement through Crisis Stabilizers*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for the project. – The organization clearly identified the PIP population in relation to the aim statement for the project. – The organization selected PIP variables and performance measures that were clear indicators of performance for the project. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for the project. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for the project. **Progress** – The PIP used defined and measurable variables to adequately address the aim statement.

WM	
Programs Operated	**CY 2022 Enrollment by Program**
Wraparound Milwaukee	741
Findings	
	– The performance measures enabled the organization to monitor results of the project during the measurement year. – The data analysis plan was specified in the PIP report. – The PIP project specified a repeat measure. – PIP results and findings were clearly presented in a concise and easily understood manner. **Recommendations** – Ensure the description of the baseline and repeat measurements in the aim statements align. – Include evidence of statistical analysis to assess differences between initial and repeat measures. – Conduct and document a comparison of PIP results to another entity, population, or relevant data source within the organization. – Continue to build a methodologically sound PIP to ensure project results demonstrate an improvement from the baseline rates for each study question or aim statement.
Protocol 2: Validation of Performance Measures	There are no measures to report. DHS is currently working to develop measures.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	Not applicable. WM's last Compliance with Standards Review was conducted in CY 2021.
Appendix A: Information Systems Capabilities Assessments	Not applicable. WM's last ISCA was conducted in CY 2021.

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

CHW	
Programs Operated	**CY 2022 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
Care Management Review *Care Management Review* *Sample Size: 30*	**Strengths** – The organization had processes in place to ensure that members met program eligibility requirements and voluntary consent was obtained. – Care plans were comprehensive as evidenced by inclusion of member's needs and goals, actions or interventions to meet the goals, and timeframes for interventions.

CHW	
Programs Operated	**CY 2022 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
	– The organization had processes in place to ensure that care plans were completed timely. – Member specific medical, social, and educational needs were addressed and documented in the records. – 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** – Progress was evidenced in comprehensive assessments and comprehensive care plans. **Recommendations** – The organization should evaluate the process for reconciling the enrollment file to ensure accurate census is provided to DHS.

MCH	
Programs Operated	**CY 2022 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
Care Management Review *Care Management Review* *Sample Size: 10*	**Strengths** – The organization had processes in place to ensure members met program eligibility requirements and voluntary consent was obtained. – The organization completed comprehensive and timely assessments of member's medical, social, and educational needs. – The organization had processes in place to ensure mutual agreement and advance notice of service reductions or termination from the program when needed. – The CMC program staff met or exceeded minimal contact requirements with families to ensure identified needs were met and services were provided in accordance with the care plan. – When applicable, follow-up after hospitalization was documented. – 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** – The hospital demonstrated progress, specifically in the area of comprehensiveness of care plans as evidenced by care plans with goals that were child-centric and addressed all identified needs. **Recommendations** – Continue to focus on comprehensiveness of care plans, including actions necessary to meet identified goals.

AFCH	
Programs Operated	**CY 2022 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
Care Management Review *Care Management Review* *Sample Size: 30*	**Strengths** – The organization had processes in place to ensure that all members met program eligibility. – 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 exceeded the amount of contact required and addressed member concerns quickly to avoid emergency department visits and hospitalizations. – The organization had processes in place to coordinate and follow-up on referrals for each member to ensure ongoing and quality care. – Due to an increase in calls from families about mental health issues during Coronavirus – 2019 (COVID-19) pandemic, a newsletter, geared towards families of children with complex health issues, was sent to all families in the program to provide resources and guidance for mental health needs. Additionally, a back to school newsletter was sent to address back to school concerns during COVID-19, – A new medical transportation vendor was put in place and many issues arose as a result. The organization was instrumental in helping families work through these issues with the provider. **Progress** – The organization made progress in ensuring that member needs were addressed. **Recommendations** – Ensure comprehensiveness of care plans by documenting actions and interventions for goals in the plans.

Vivent Health	
Programs Operated	**CY 2021 Enrollment by Program**
HIV/AIDS Health Home	Not publicly reported
Findings	
Record Review	DHS did not direct MetaStar to conduct reviews during CY2022. Reviews will resume in CY2023.

PROTOCOL 1: VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

The Validation of Performance Improvement Projects (PIPs) is a mandatory EQR activity identified in the Code of Federal Regulations (CFR) 42 CFR 438.358 and conducted according to federal protocol standards, *CMS External Quality Review (EQR) Protocols, Protocol 1. Validation of Performance Improvement Projects*. See Appendix 2 for more information about the PIP review methodology.

DHS contractually requires organizations operating BadgerCare+, SSI, Children Come First, Wraparound Milwaukee, and the Foster Care Medical Home (FCMH) to annually make active progress on at least one clinical and one non-clinical PIP. MCOs operating more than one of these programs may fulfill this PIP requirement by conducting one or both of the required PIPs with members from any or all programs. If the MCO chooses to combine programs in a single PIP, the baseline and outcome data must be separated by program enrollment.

The PIP validation review was revised at the start of this calendar year to align with the Centers for Medicare & Medicaid Services External Quality Review Protocols, which define the review activities for Medicaid Managed Care Programs. As a result of the revisions, the year-to-year aggregated results are no longer comparable.

The study methodology is assessed through the following steps:

- Review the selected PIP topic(s);
- Review the PIP aim statement(s);
- Review the identified PIP population;
- Review sampling methods (if sampling used);
- Review the selected PIP variables and performance measures;
- Review the data collection procedures;
- Review the data analysis and interpretation of PIP results
- Assess the improvement strategies; and
- Assess the likelihood that significant and sustained improvement occurred.

DHS requires MCOs and PIHPs to submit each PIP project for pre-approval by providing a preliminary summary which states the proposed topic, study question, and a brief description of the planned interventions and study design. Both DHS and the EQRO review the PIP preliminary proposals; DHS determines if the selected topic is aligned with Department goals, and the EQRO reviews the methodology and study design proposed by the MCO. This activity is considered PIP technical assistance. For projects conducted during CY 2021, organizations submitted proposals for all projects to DHS and MetaStar by December 1, 2020. DHS directed MCOs to submit final reports by July 1, 2022.

Overall PIP Results

Compliance with PIP requirements is expressed in terms of a percentage score based on the number of applicable scoring elements, and a validation rating, as identified in the table below. The validation rating reflects the EQRO's confidence in the PIP's methods and findings. The validation rating reflects the EQRO's confidence in the PIP's methods and findings. See Appendix 2 for more information about the scoring methodology.

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

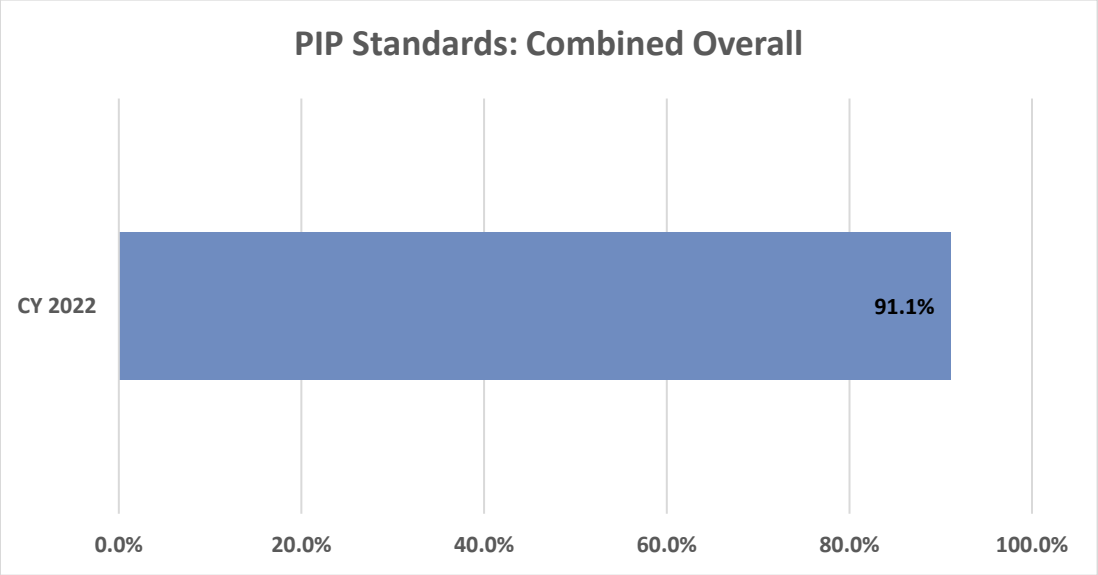
The following table lists each standard that was evaluated for each organization, and indicates the total number of scoring elements and percentage of scoring elements met for each standard. The validation result for each standard is also included. Some standards are not applicable to all projects due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

The overall score for all projects validated in CY 2022 was 91.1 percent, with a validation result of High Confidence.

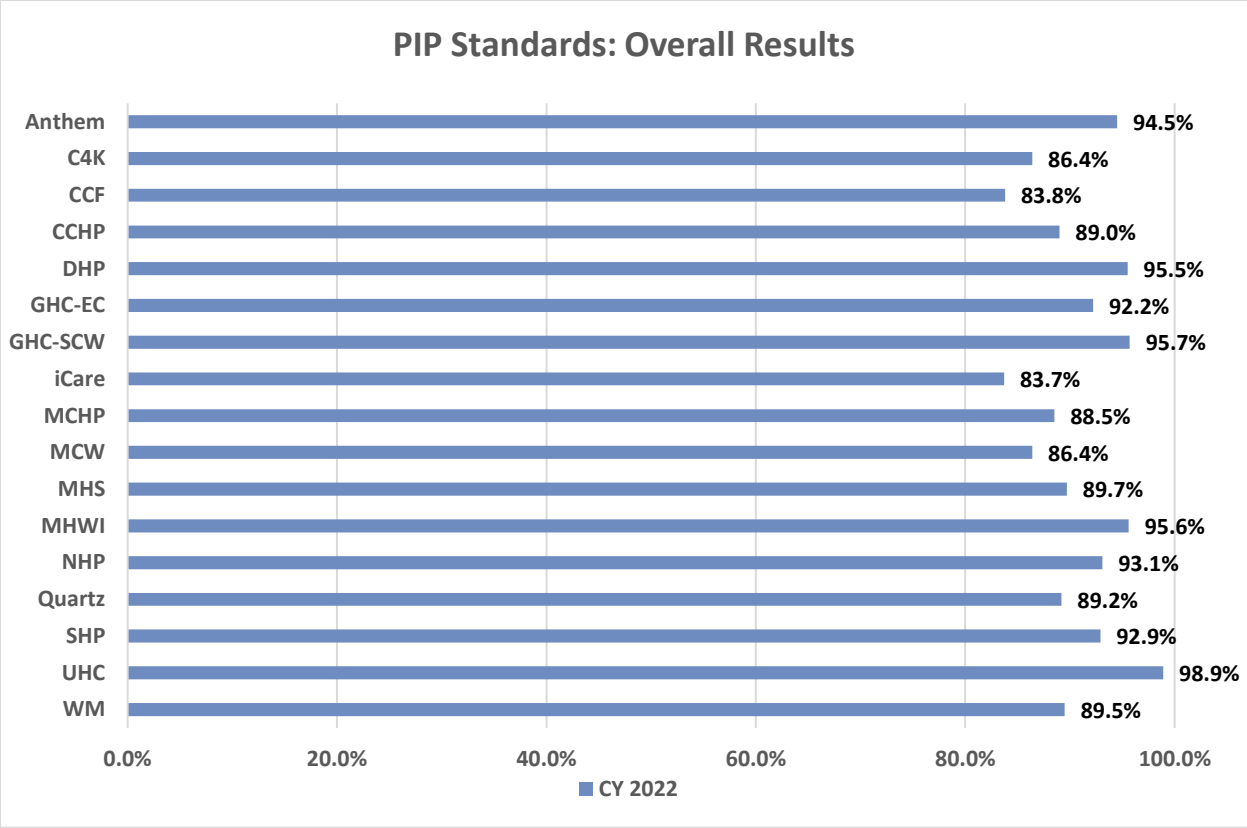
Performance Improvement Project Validation Review CY 2022			
Standard	**Scoring Elements**	**Percentage**	**Validation Result**
Standard 1: PIP Topic	107/107	100.0%	High Confidence
Standard 2: PIP Aim Statement	184/198	92.9%	High Confidence
Standard 3: PIP Population	66/66	100.0%	High Confidence
Standard 4: Sampling Method*	N/A	N/A	N/A
Standard 5: PIP Variables and Performance Measures	206/207	99.5%	High Confidence
Standard 6: Data Collection Procedures	317/321	98.8%	High Confidence
Standard 7: Data Analysis and Interpretation of PIP Results	170/219	77.6%	Low Confidence
Standard 8: Improvement Strategies	189/198	94.5%	High Confidence
Standard 9: Significant and Sustained Improvement	55/104	52.9%	No Confidence
Overall	**1294/1420**	**91.1%**	**High Confidence**

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

The graph below illustrates the State's overall compliance with these standards in CY 2022. As indicated above, the year-to-year results are no longer comparable due to the revisions to the PIP validation; therefore, comparisons to prior PIP validations are not included.



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



Results for each PIP Standard

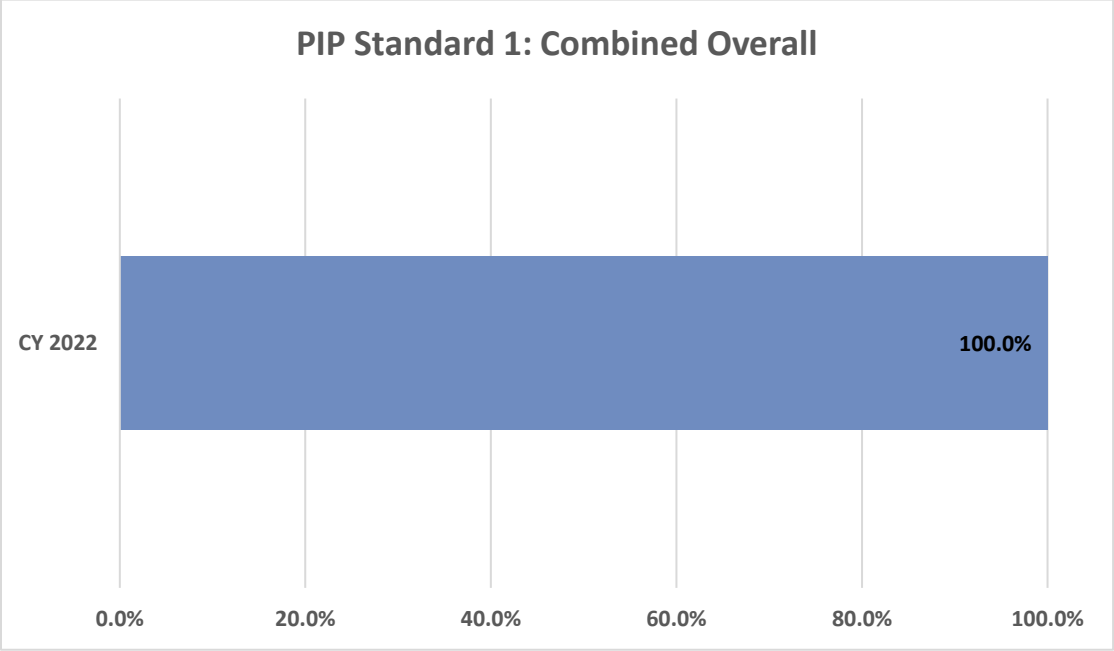
Each section that follows provides a brief explanation of the PIP standards, including rationale for any areas the MCOs were not fully compliant. Additionally, Appendix 3 includes results for each standard by MCO.

Observation and Analysis: Standard 1. PIP Topic

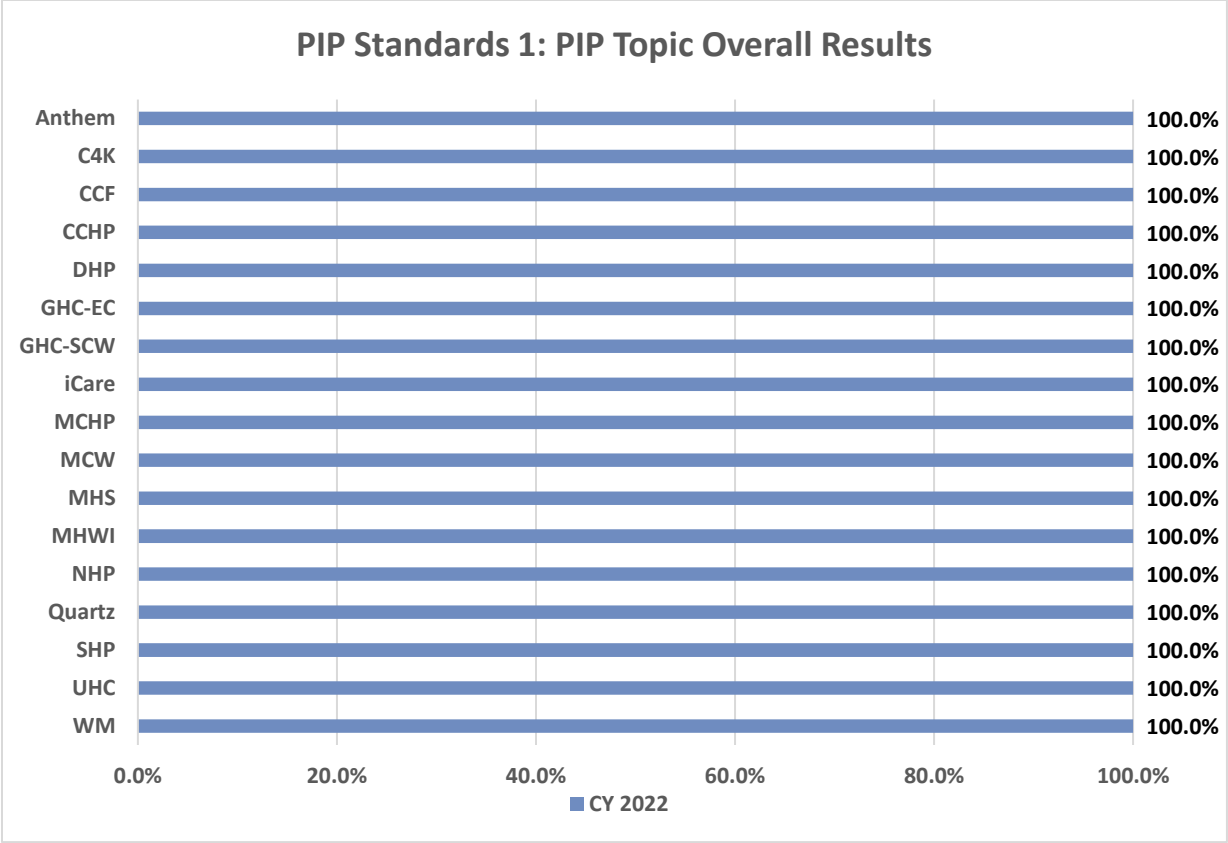
The organizations should target improvement in relevant areas of clinical and non-clinical services. The topic selection process should consider the national Quality Strategy, CMS Core Set Measures, and DHS priorities. When appropriate or feasible, enrollee and provider input should be obtained. All topics should address areas of special populations or high priority services. Standard 1 evaluates each PIP on five possible scoring elements. Collectively, the organizations satisfied requirements for 107 out of 107 scoring elements, for a score of 100.0 percent.

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

The graph below illustrates the State's overall compliance with this standard in CY 2022. As indicated above, the year-to-year results are no longer comparable due to the revisions to the PIP validation; therefore, comparisons to prior PIP validations are not included.



The graph on the next page illustrates each organizations' overall compliance with this standard.

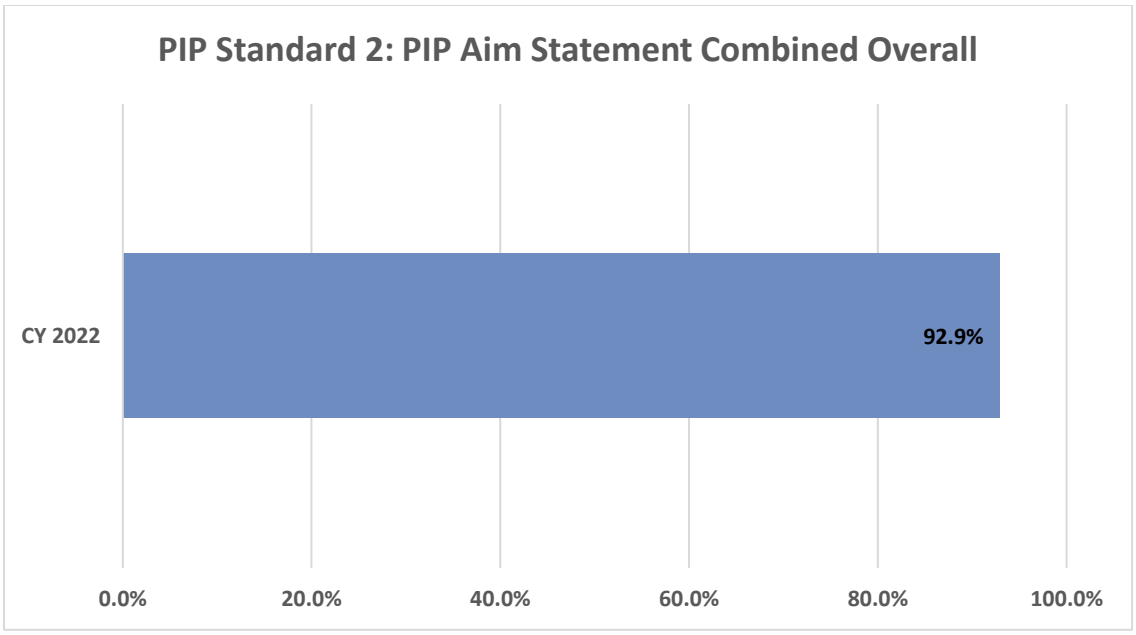


Observation and Analysis: Standard 2. PIP Aim Statement

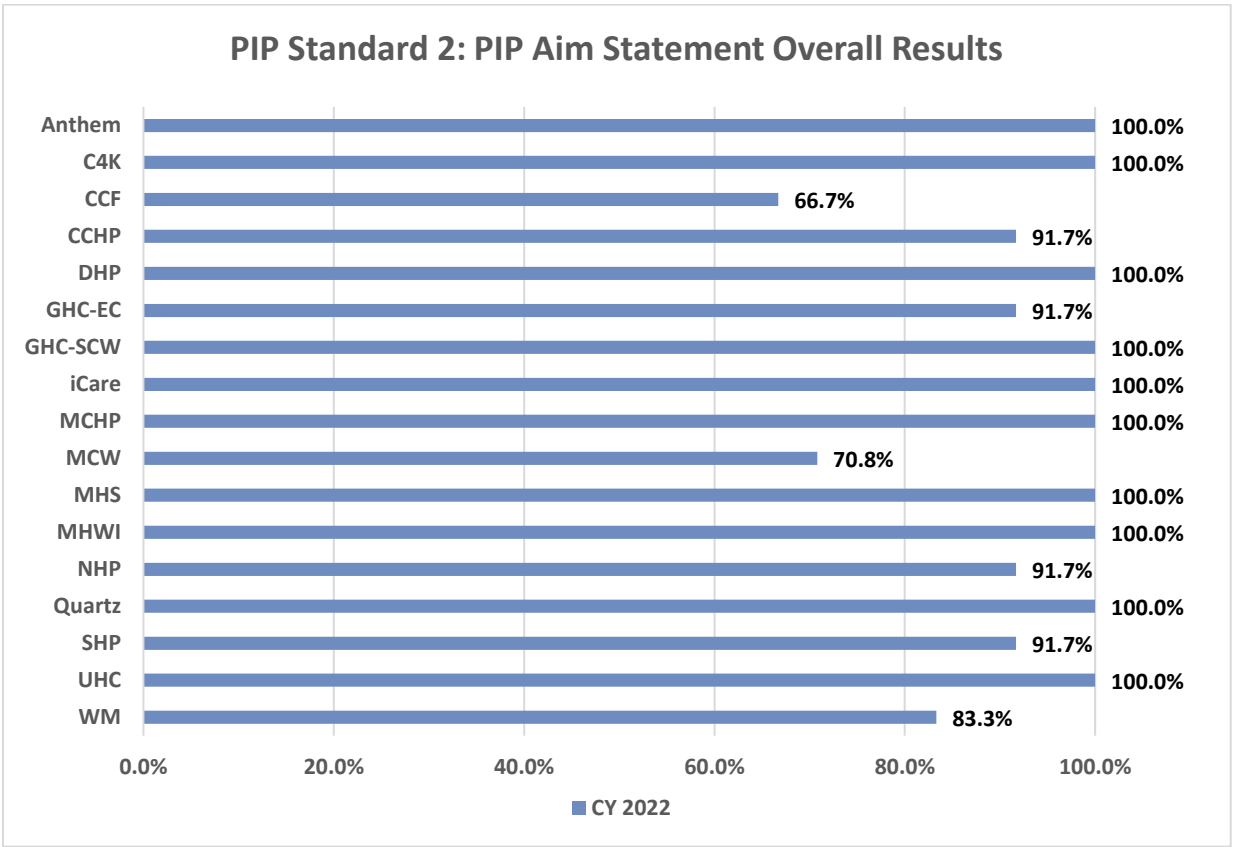
The PIP aim statement identifies the focus of the PIP and establishes the framework for data collection and analysis. It should be a clear, concise, measurable, and answerable statement or question that identifies the improvement strategy, population, and time period. Standard 2 evaluates each PIP on six possible scoring elements. Collectively, the organizations satisfied requirements for 184 out of 198 scoring elements, for a score of 92.9 percent.

Projects included aim statements that satisfied most scoring elements of this standard. DHS designated interventions for organizations to utilize for PIPs to improve postpartum care rates and other health disparities. Some organizations also chose to utilize these interventions for additional PIP topics.

The graph on the next page illustrates the State's overall compliance with this standard in CY 2022. As indicated above, the year-to-year results are no longer comparable due to the revisions to the PIP validation; therefore, comparisons to prior PIP validations are not included.



The graph below illustrates each organizations' overall compliance with this standard.

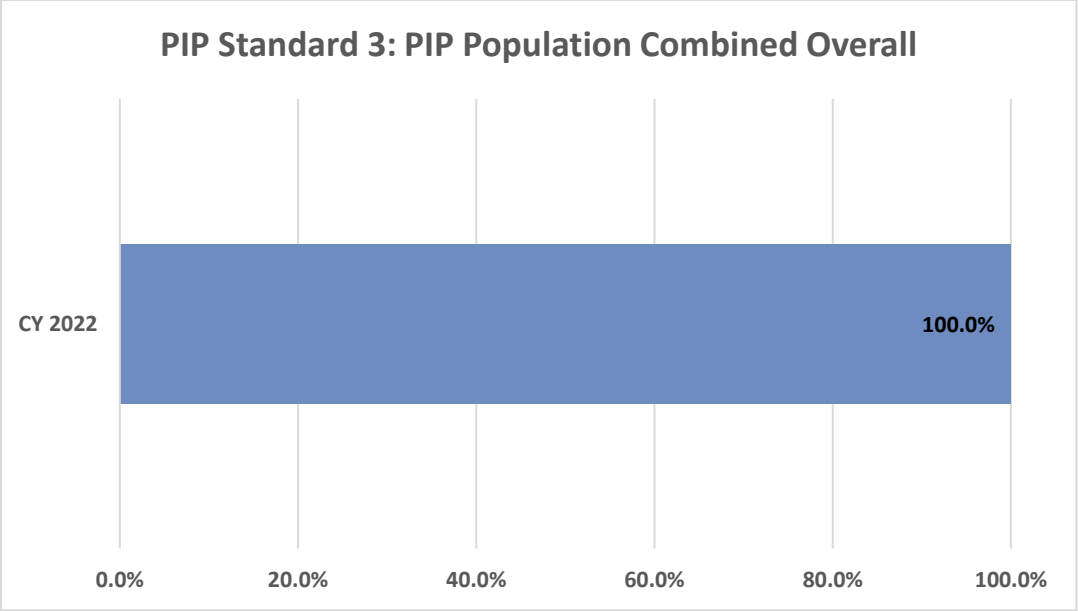


Observation and Analysis: Standard 3. PIP Population

The organizations must clearly define the project's population, identifying all inclusionary and exclusionary criteria. If the entire eligible MCOs population is included in the project, the data collection approach must ensure it captures all applicable members. Standard 3 evaluates each PIP on two possible scoring elements. Collectively, the organizations satisfied requirements for 66 out of 66 scoring elements, for a score of 100.0 percent.

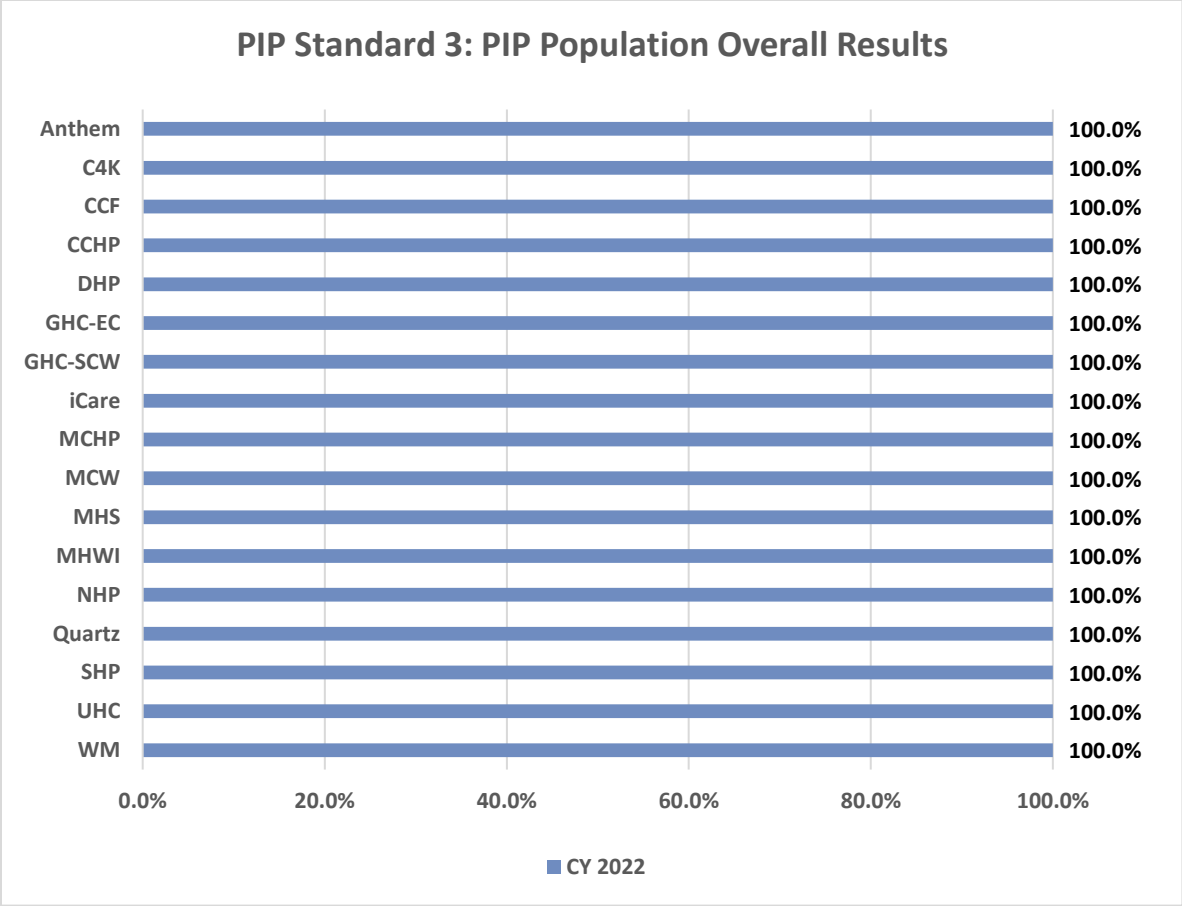
All organizations clearly defined the project populations. The organizations using Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measures used the appropriate specifications for the project populations identified in the aim statements.

The graph below illustrates the State's overall compliance with this standard in CY 2022. As indicated above, the year-to-year results are no longer comparable due to the revisions to the PIP validation; therefore, comparisons to prior PIP validations are not included.



The graph on the next page illustrates each organizations' overall compliance with this standard.

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



Observation and Analysis: Standard 4. Sampling Method

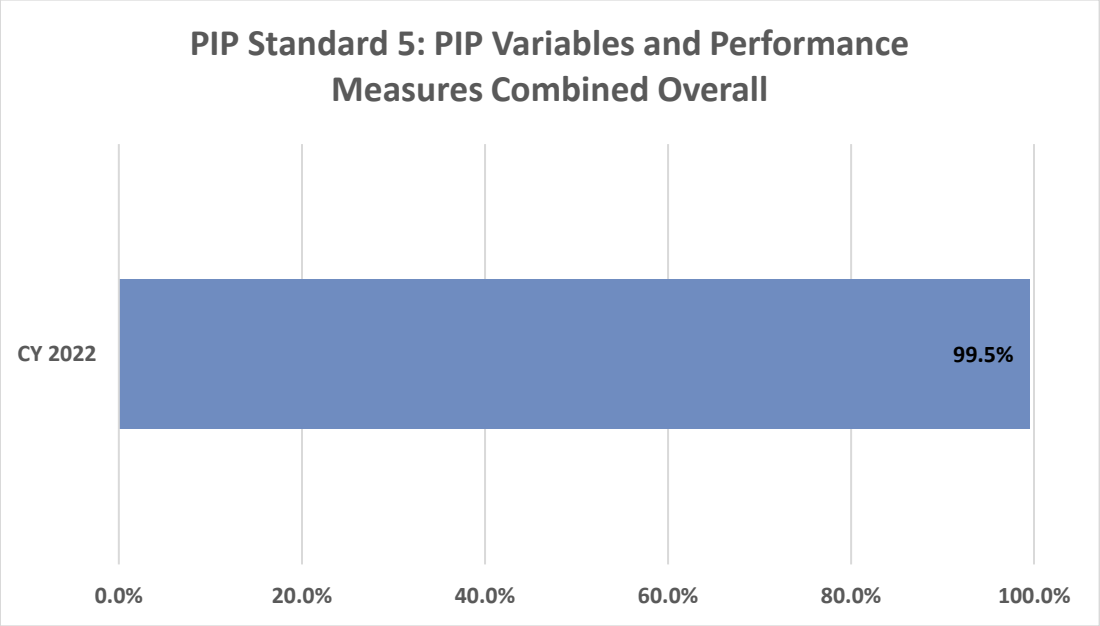
The organizations must have appropriate sampling methods to ensure data collection produces valid and reliable results. The organizations did not utilize sampling for the project.

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

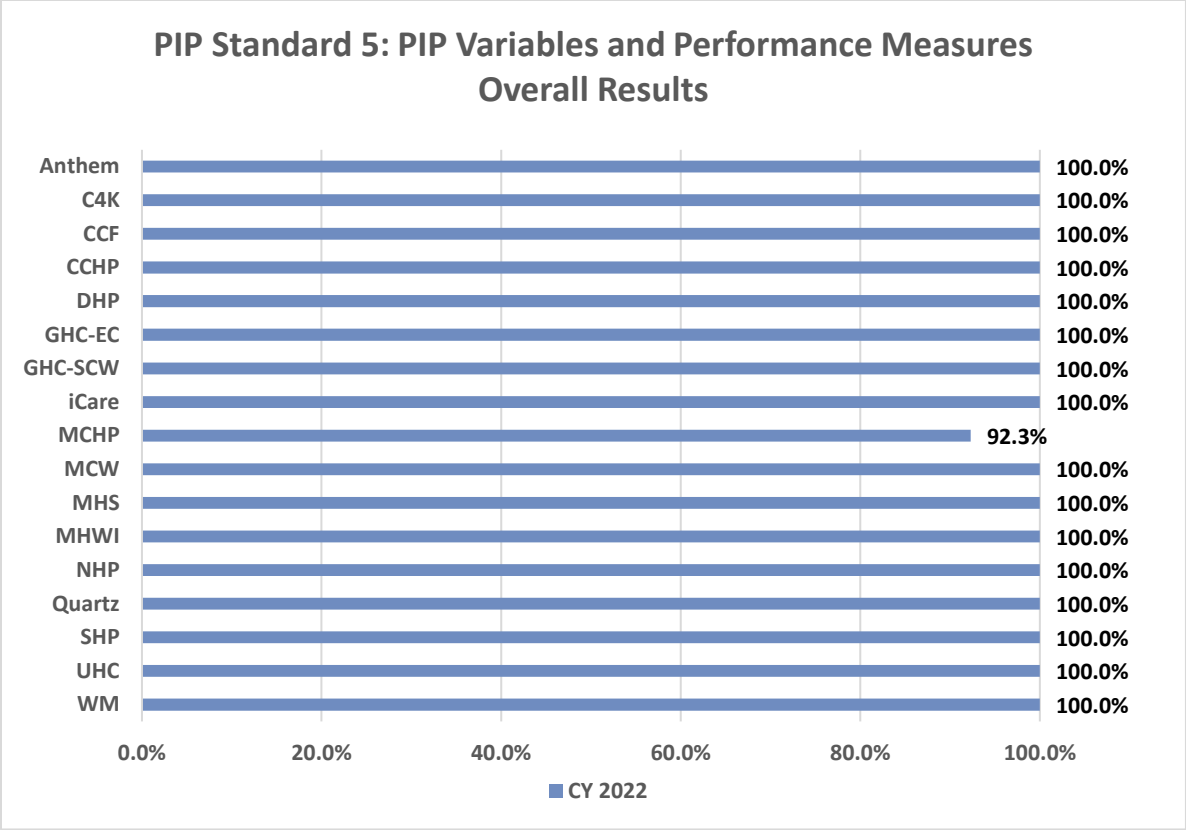
Organizations must select variables that identify the organizations' performance on the PIP questions objectively and reliably, using clearly defined indicators of performance. The PIP should include the number and type of variables that are adequate to answer the PIP question, can measure performance, and can track improvement over time. Standard 5 evaluates each PIP on 10 possible scoring elements. Collectively, the organizations satisfied requirements for 206 out of 207 scoring elements, for a score of 99.5 percent.

HEDIS® measures were used for the majority of projects. HEDIS® measures are based on current clinical knowledge and research, and also allows results to be compared with other organizations and populations.

The graph below illustrates the State's overall compliance with this standard in CY 2022. As indicated above, the year-to-year results are no longer comparable due to the revisions to the PIP validation; therefore, comparisons to prior PIP validations are not included.



The graph on the next page illustrates each organizations' overall compliance with this standard.



Observation and Analysis: Standard 6. Data Collection Procedures

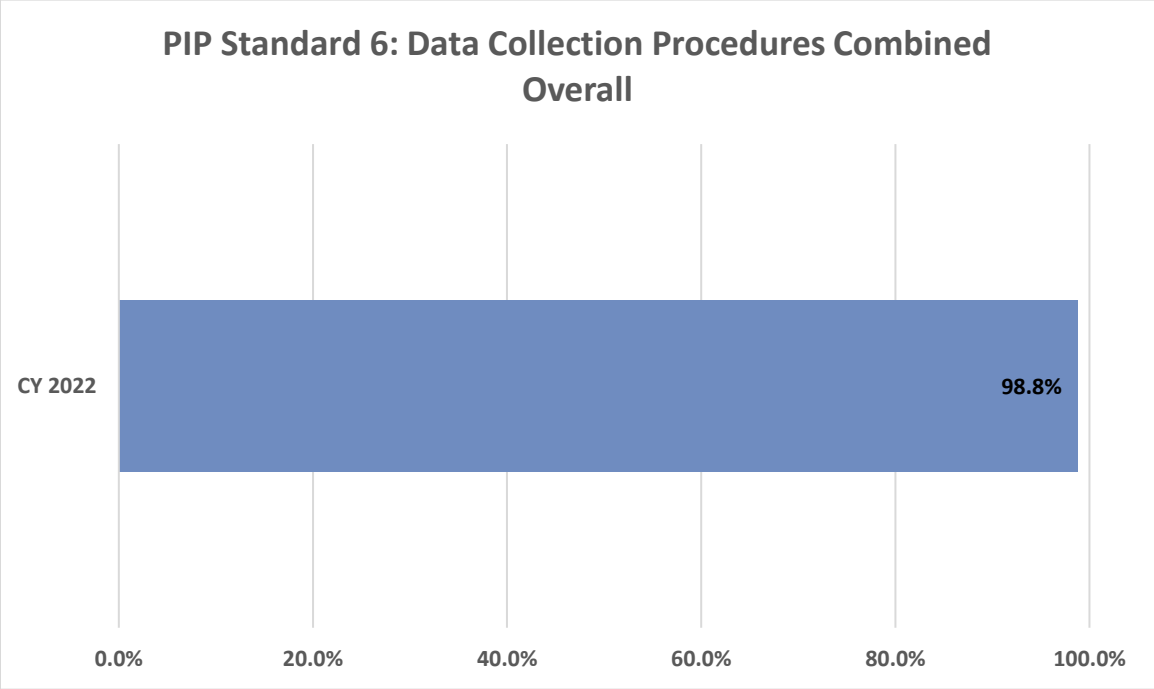
Organizations must establish data collection procedures that ensure valid and reliable data throughout the project. The data collection plan should specify the following:

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

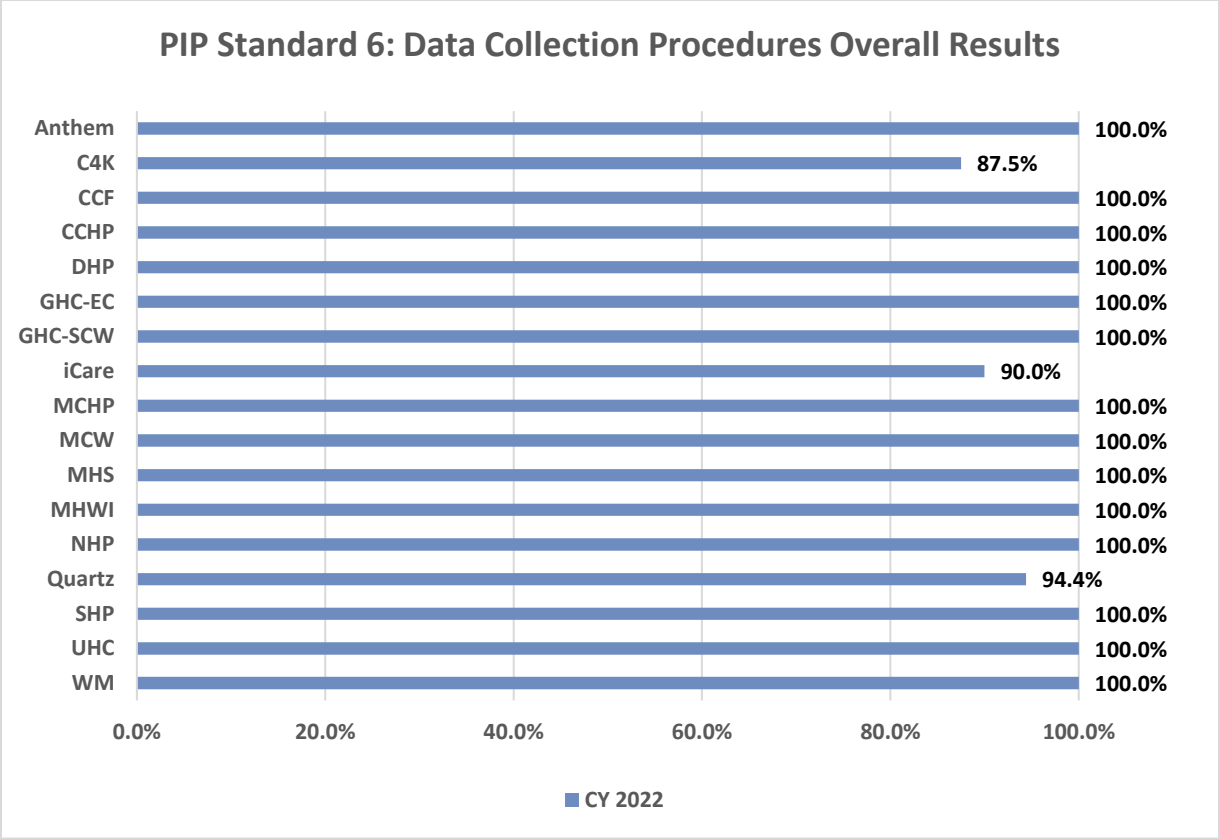
Standard 6 evaluates each PIP on 17 possible scoring elements. Collectively, the organizations satisfied requirements for 317 out of 321 scoring elements, for a score of 98.8 percent.

Organizations included data collection procedures in the reports and ensured the data collection plans aligned with the data analysis needs. The organizations using HEDIS® measures identified HEDIS® certified software providers to collect and analyze administrative data. When medical record review was utilized reports included a list of staff completing the reviews and practices to ensure inter-rater reliability.

The graph below illustrates the State's overall compliance with this standard in CY 2022. As indicated above, the year-to-year results are no longer comparable due to the revisions to the PIP validation; therefore, comparisons to prior PIP validations are not included.



The graph on the next page illustrates each organizations' overall compliance with this standard.



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

Organizations must use appropriate techniques to conduct analysis and interpretation of the PIP results. The analysis should include an assessment of the extent to which any change in performance is statistically significant. Standard 7 evaluates each PIP on eight possible scoring elements. Collectively, the organizations satisfied requirements for 170 out of 219 scoring elements, for a score of 77.6 percent.

Scoring element 7.1 assesses if the project's analysis was conducted in accordance with the data analysis plan. Several reports had inconsistencies between quarterly and monthly data collection or included medical record reviews that were not part of the data collection plan. This did not satisfy the requirements for scoring element 7.1. MetaStar recommends organizations complete the data analysis according to the data analysis plan or explain why there was deviation from the plan when needed.

Scoring element 7.3 assesses the statistical significance of any differences between the initial and repeat measures. The majority of projects did not include the use of statistical tests in order to assess any statistically significant differences. This did not satisfy the requirements of scoring

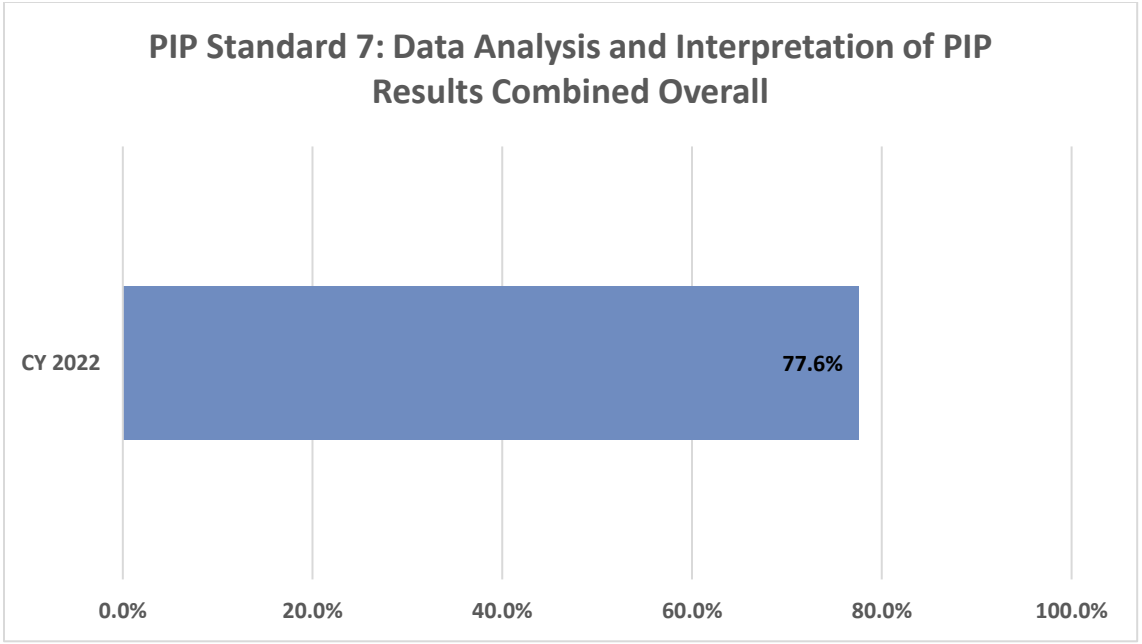
element 7.3 MetaStar recommends organizations include evidence of statistical analysis to assess differences between the initial and repeat measurements.

Scoring element 7.4 assesses if the analysis accounts for factors that may influence comparability of the initial and repeat measures. Some organizations utilized HEDIS® measures that had a break in trending, and others changed the population's exclusionary criteria for the project's aim. In both instances the ability to compare baseline and repeat measures would be impacted. If an organization did not include how the changes were taken into account for the data analysis, the requirements for this scoring element were not met. MetaStar recommends organizations account for factors that may influence the comparability of initial and repeat measures in future reports.

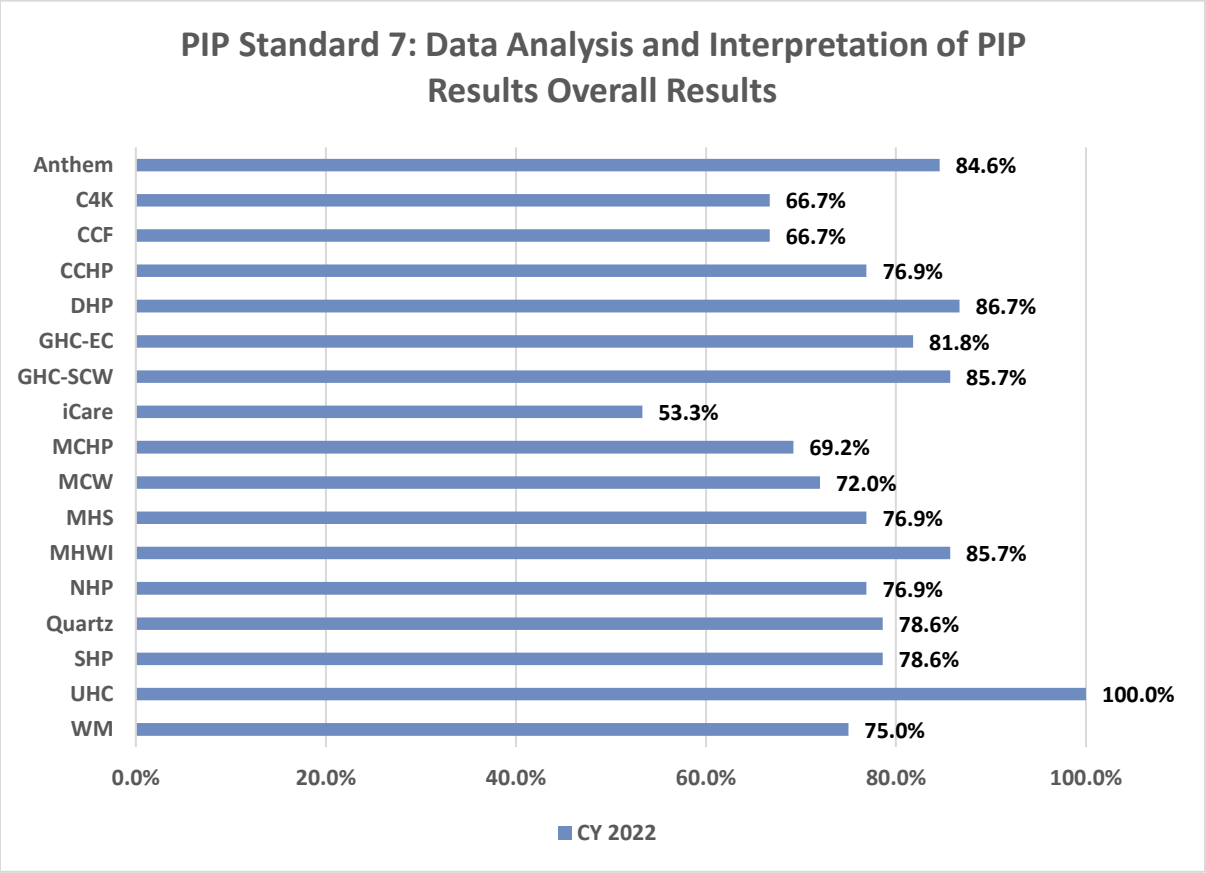
Scoring element 7.6 evaluates if results are compared across multiple entities, such as different patient subgroups, provider sites, or organizations. If an organization did not compare results to any other entity or subgroup, the requirements for scoring element 7.6 were not satisfied. MetaStar recommends organizations perform and document an analysis comparing the PIP results to other entities or population subgroups.

Scoring Element 7.7 evaluates that results and findings were presented in a concise and easily understood manner. Several reports included incorrect information or presented the information in a confusing manner which did not satisfy the requirements for scoring element 7.7. MetaStar recommends organizations present PIP findings in a clear and understandable manner.

The graph below illustrates the State's overall compliance with this standard in CY 2022. As indicated above, the year-to-year results are no longer comparable due to the revisions to the PIP validation; therefore, comparisons to prior PIP validations are not included.



The graph below illustrates each organizations' overall compliance with this standard.

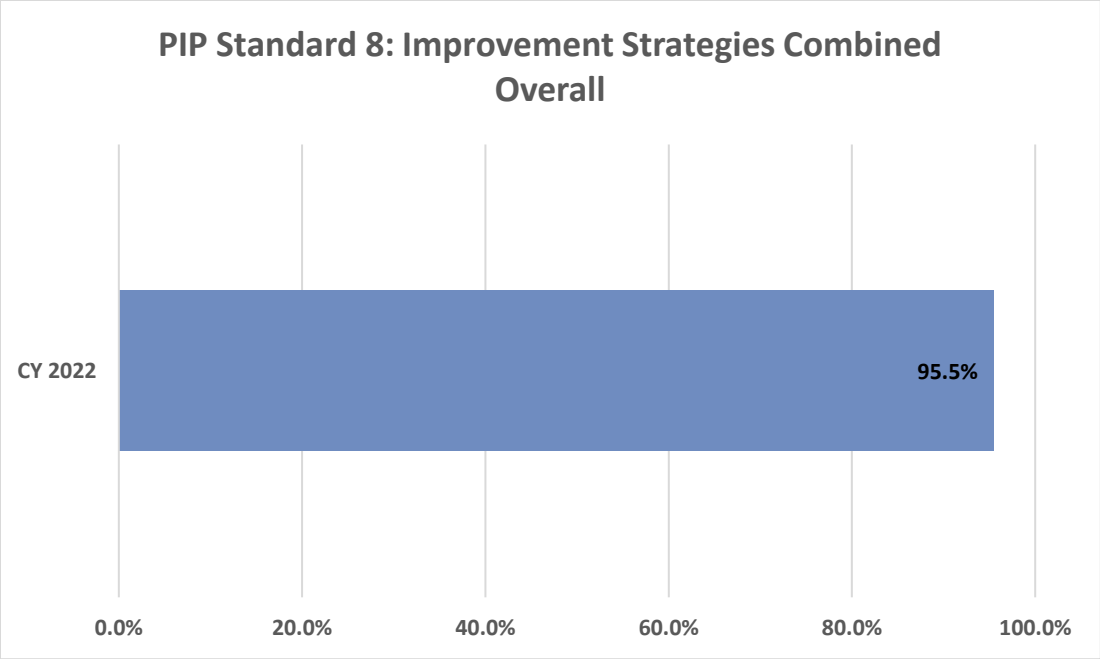


Observation and Analysis: Standard 8. Improvement Strategies

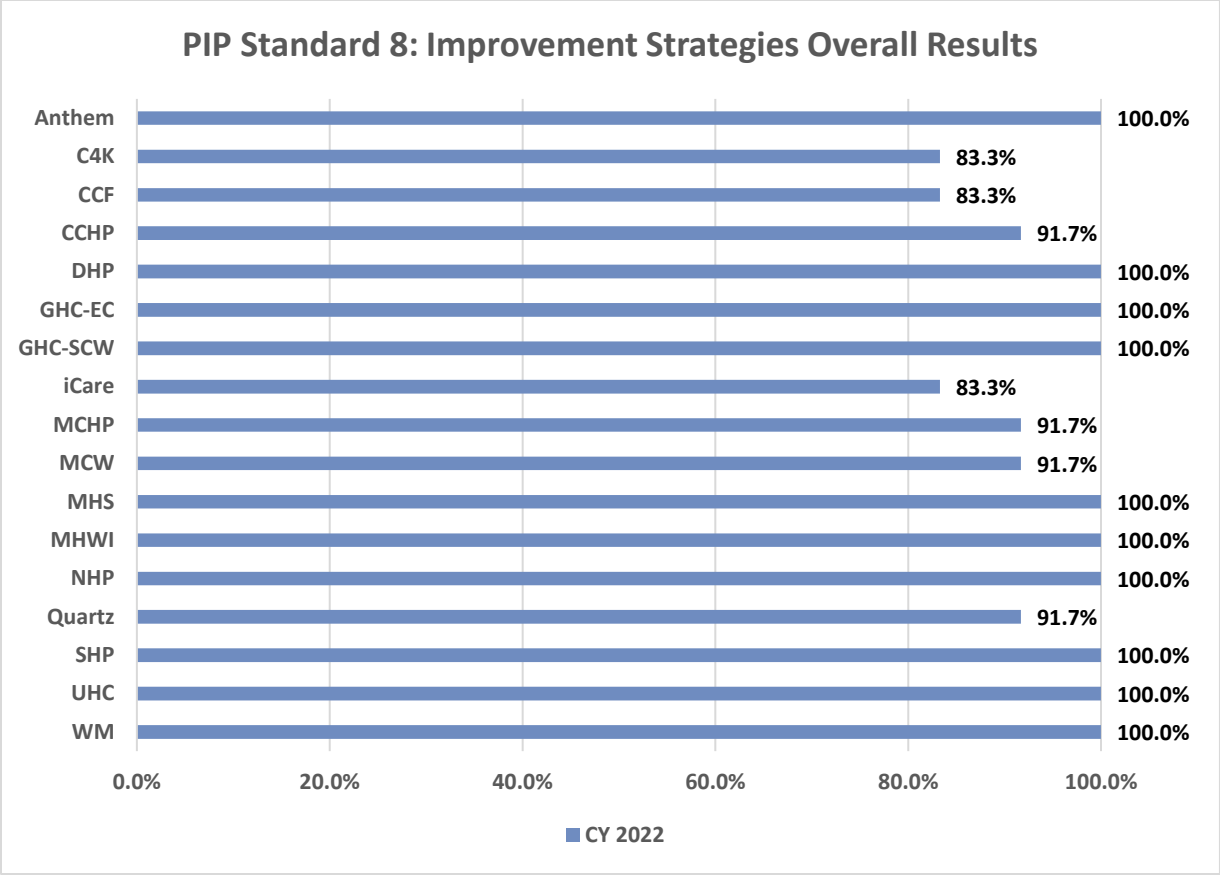
Organizations should select improvement strategies that are evidence-based, suggesting they would likely lead to the desired improvement. The effectiveness of the strategies is determined by measuring the change in performance according to the measures identified in Standard 5. Standard 8 evaluates each PIP on six possible scoring elements. Collectively, the organizations satisfied requirements for 189 out of 198 scoring elements, for a score of 95.5 percent.

Organizations utilized improvement strategies that were well designed and able to adjust to project needs. The reports included how the organizations addressed cultural and linguistic considerations in implementing their improvement strategies.

The graph on the next page illustrates the State's overall compliance with this standard in CY 2022. As indicated above, the year-to-year results are no longer comparable due to the revisions to the PIP validation; therefore, comparisons to prior PIP validations are not included.



The graph on the next page illustrates each organizations' overall compliance with this standard.



Observation and Analysis: Standard 9. Significant and Sustained Improvement

An important component of a PIP is to demonstrate sustained improvement. The organizations should conduct repeated measurements using the same methodology and document if a significant change in performance relative to the baseline occurred. Standard 9 evaluates each PIP on five possible scoring elements. Collectively, the organizations satisfied requirements for 55 out of 104 scoring elements, for a score of 52.9 percent.

Scoring element 9.1 assesses if the same methodology was used for the project's baseline and repeat measurements. Several reports included measures with a break in HEDIS® trending or had other changes in the measures that did not satisfy the requirements for scoring element 9.1. MetaStar recommends organizations ensure a consistent methodology for both the baseline and repeat measurement.

Scoring element 9.2 evaluates if there was quantitative evidence of improvement in processes or outcomes of care. Projects that did not demonstrate an improvement from the baseline measure did not satisfy the requirement for scoring element 9.2. MetaStar recommends organizations

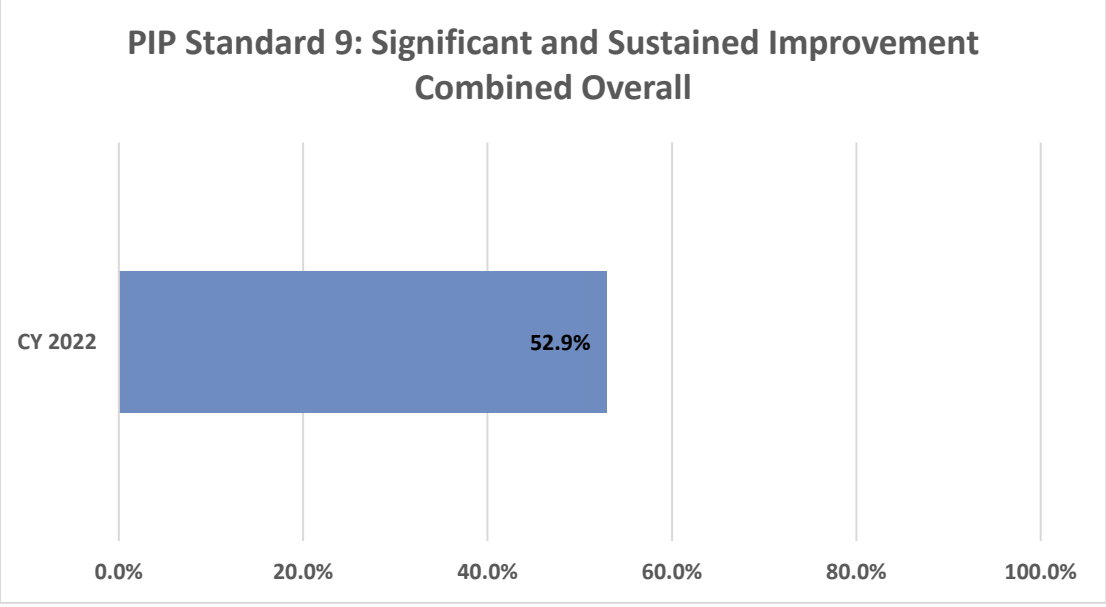
continue to build methodologically sound performance improvement projects to demonstrate improvement from baseline to repeat measurements.

Scoring element 9.3 assesses that the reported improvement in performance was likely the result of selected improvement strategies. Organizations that did not use the same methodology for the project's baseline and repeat measure are unable to conclude the improvement was likely the result of the selected improvement strategies. This did not satisfy the requirements for scoring element 9.3. MetaStar recommends organizations use consistent methodology to demonstrate improvement due to PIP interventions.

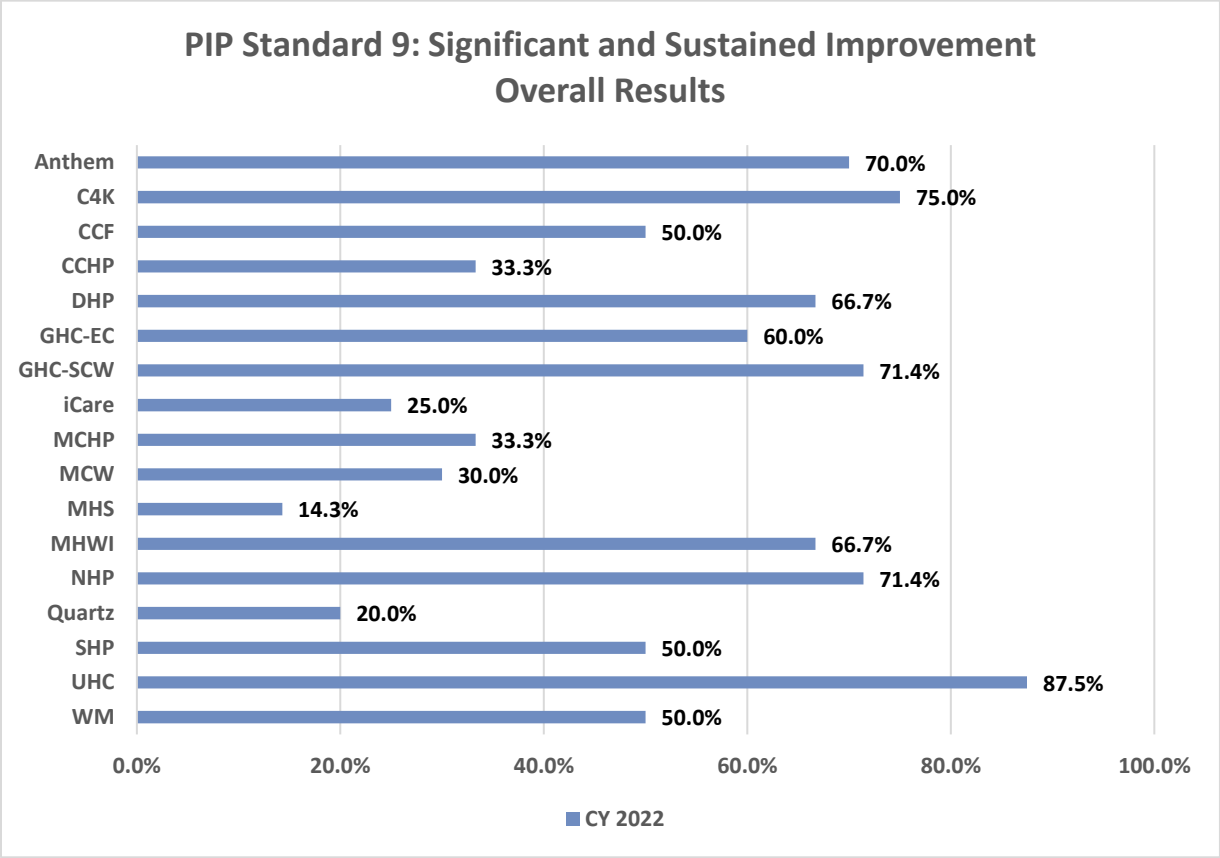
Scoring element 9.4 assesses if there is statistical evidence that any observed improvement is the result of the intervention. Organizations that did not complete any testing for statistical significance did not satisfy the scoring requirements for scoring element 9.4. MetaStar recommends organizations include statistical analysis of improvement in future reports.

Scoring element 9.5 evaluates if sustained improvement was demonstrated through repeated measurements over time. Projects would have to sustain improvement every year from the baseline year to the current measurement year. If a project had a decrease in results or had a change in methodology, the scoring requirements for scoring element 9.5 were not satisfied. MetaStar recommends organizations continue to build a methodologically sound project to increase the probability of sustained improvement for projects spanning multiple years.

The graph below illustrates the State's overall compliance with this standard in CY 2022. As indicated above, the year-to-year results are no longer comparable due to the revisions to the PIP validation; therefore, comparisons to prior PIP validations are not included.



The graph below illustrates each organizations' overall compliance with this standard.



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 2021, reported in CY 2022, 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® scores as well as performance for other measures identified by DHS. This strategy is a key component of the DHS annual quality plan. The strategy links the mandatory *EQR Protocol 2: Validation of Performance Measures Reported by the MCO* review described in this report with some of the PIP requirements for MCOs.

DHS identifies the identified measures each year in the *Quality Guide*.

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).

Each MCO's HEDIS® measure results are validated by a National Committee for Quality Assurance (NCQA) certified HEDIS® auditor, then submitted to DHS. MetaStar did not validate the CY 2021 measures, following is an analysis of the reported results.

RESULTS

Findings are categorized into strengths, progress, and opportunities for improvement. A strength is identified as a measure rate that improved from the prior year. Progress is defined as an

improvement from the prior year as well as a rate higher than the statewide rate. An opportunity for improvement is a measure rate that is the same or lower than the prior year's rate.

The following tables identify statewide rates compared between CY2021 to CY2020

Program: BC+ Composite Measures	CY 2021	CY2020
Women's Health Composite		
Timeliness of Prenatal Care (PPC)	83.5%	85.9%
Postpartum Care (PPC)	77.7%	74.7%
Children's Health Composite		
Childhood Immunization Combo 3 (CIS)	59.4%	66.3%
Immunizations for Adolescents Combo 2 (IMA)	37.6%	38.8%
Lead Screening in Children (LSC)	65.4%	76.9%

Green identifies year to year improvement. Red identifies year to year decreases.

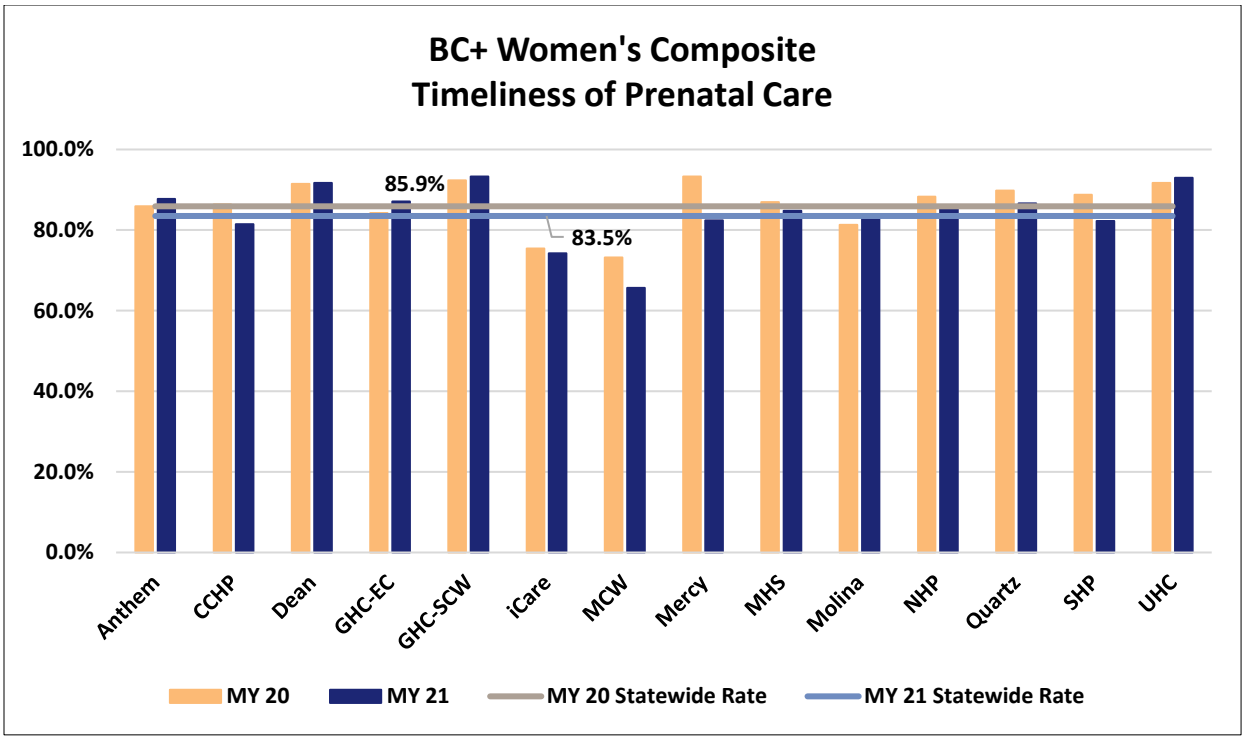
Program: SSI Composite Measures	CY2021	CY2020
Performance Measures		
Controlling Blood Pressure (CBP)	62.5%	61.6%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	8.9%	11.2%
Follow-Up after Emergency Department Visit for Mental Illness (FUM-30)	68.4%	58.7%
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-30)	21.9%	21.7%
Follow-Up after Hospitalization for Mental Illness (FUH-30)	67.6%	61.7%

Green identifies year to year improvement. Red identifies year to year decreases.

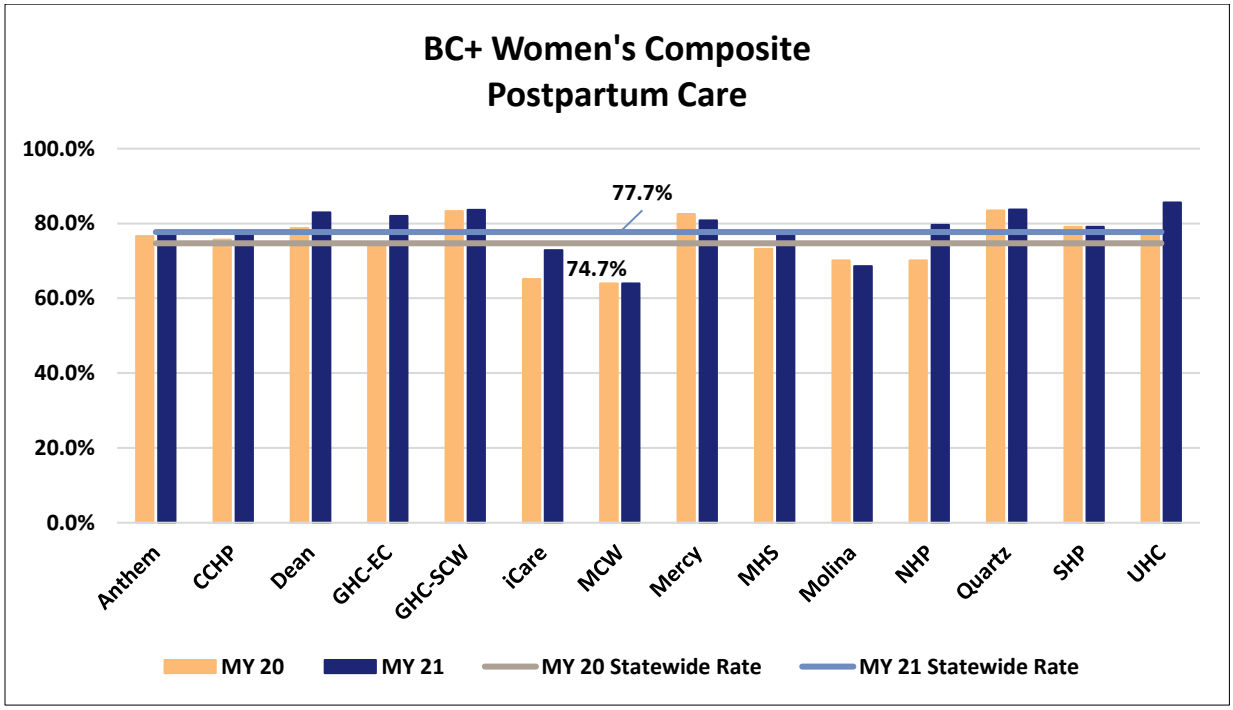
The results for each measure reported by MCO comparing CY2021 to CY2021 results as well as the statewide aggregate are summarized below.

Women's Health Composite

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

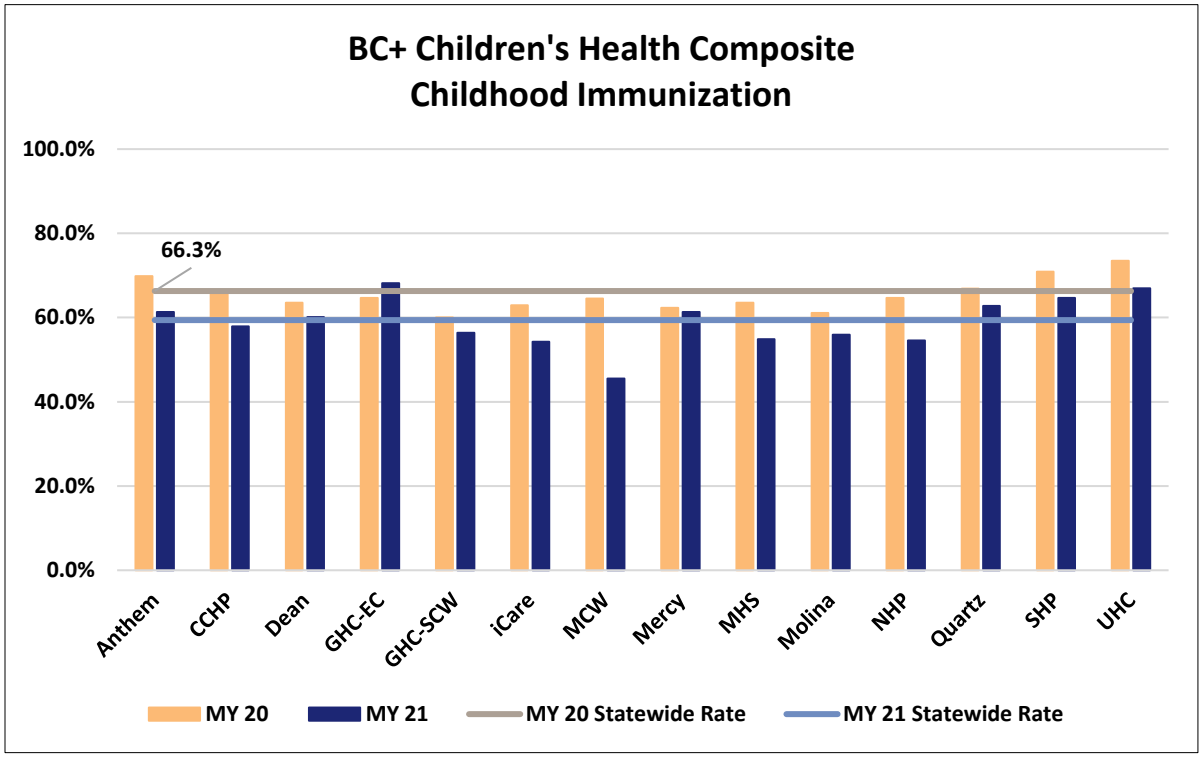


The following graph displays the results for the Postpartum Care measure by MCO.

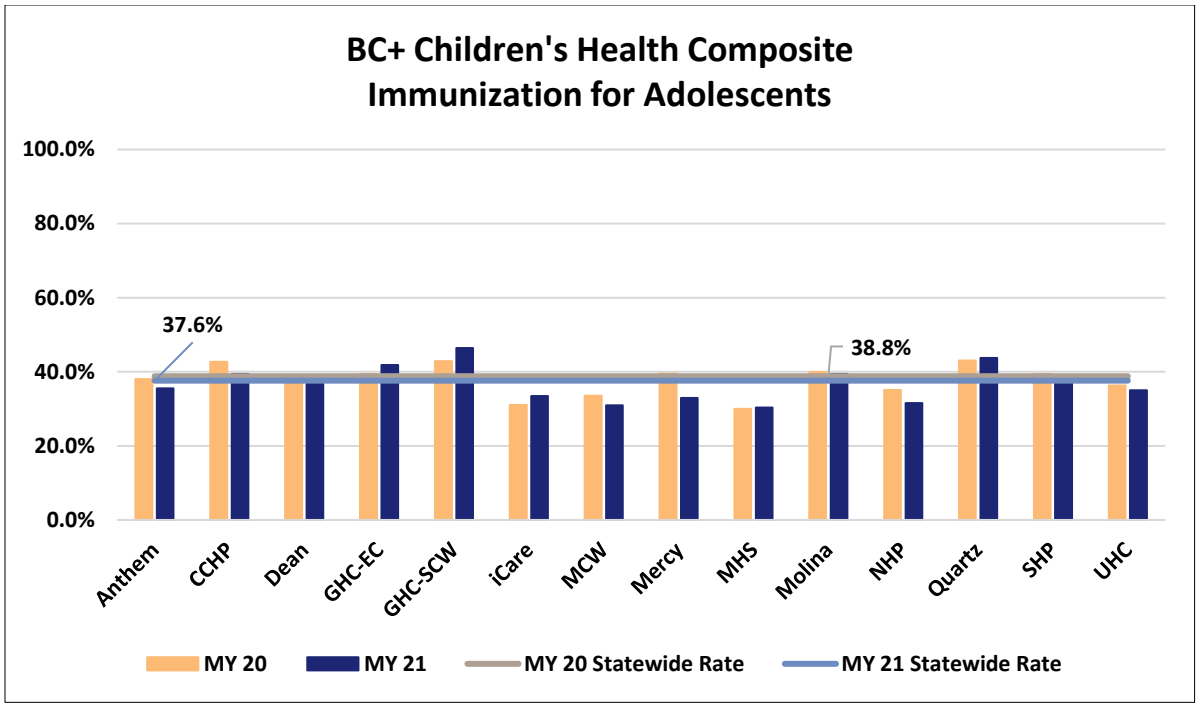


Children's Health Composite

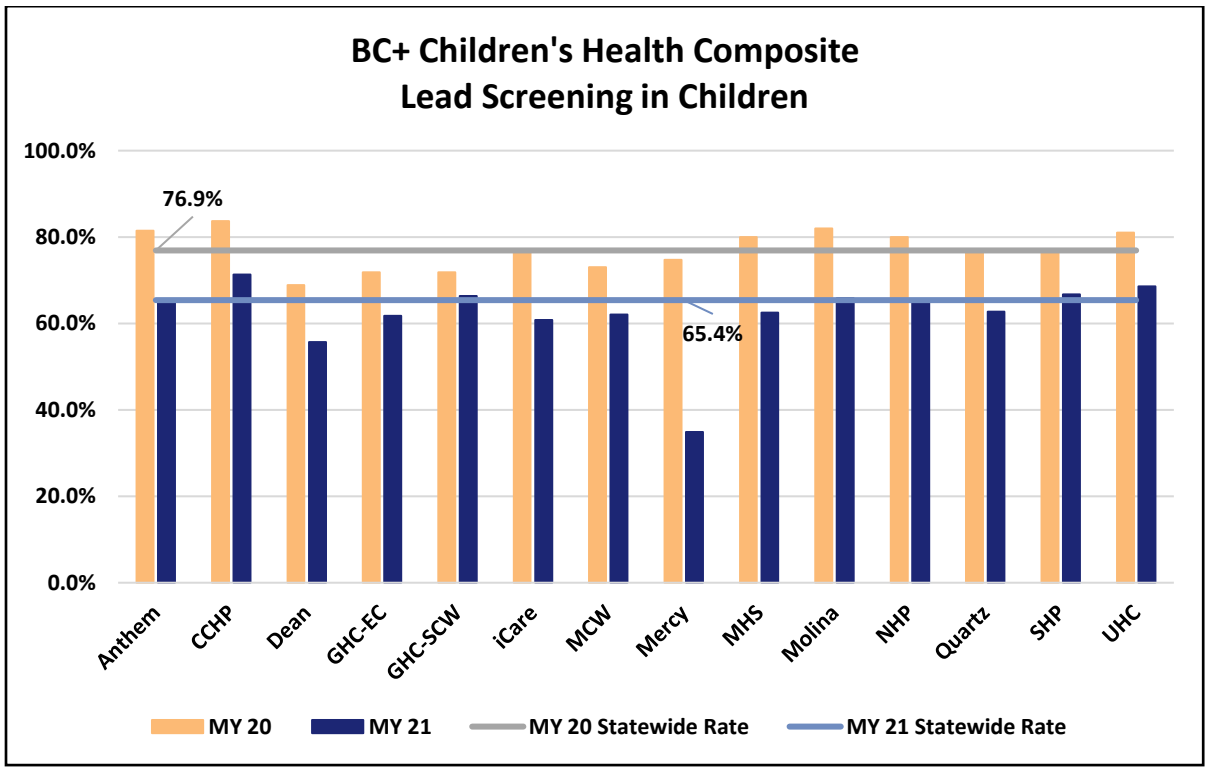
The following graph displays the results for Childhood Immunization Combo 3 by MCO.



The graph on the next page displays the results for the Immunizations for Adolescents Combo 2 by MCO.

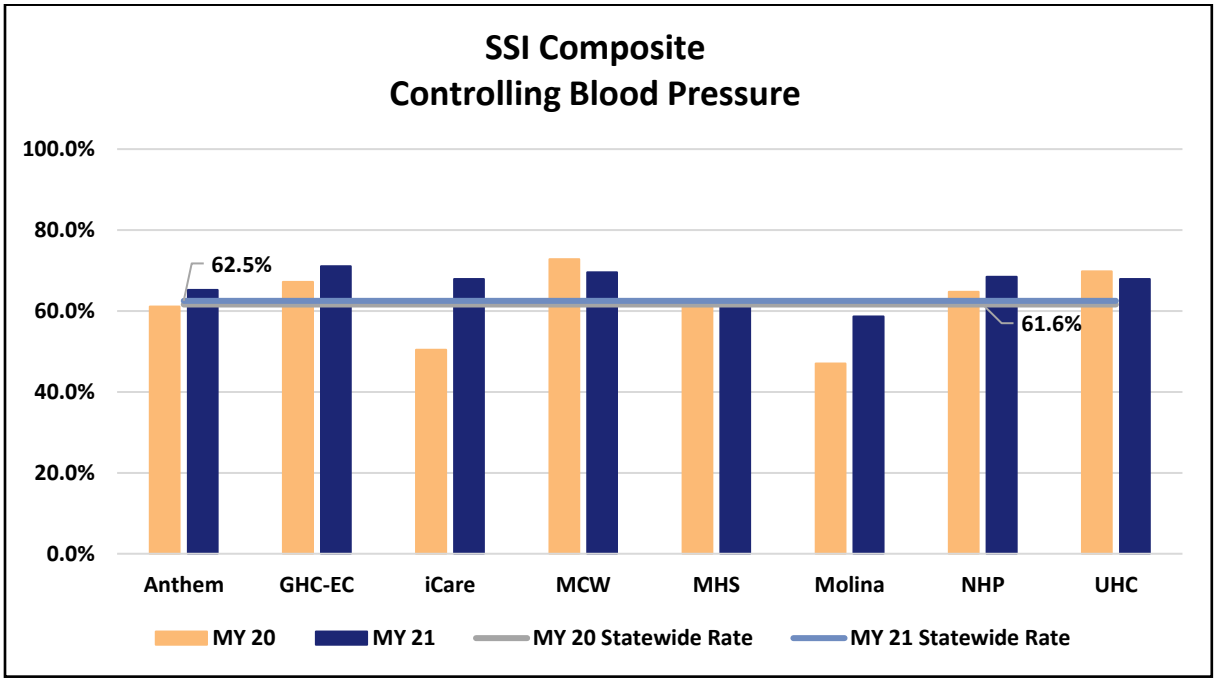


The graph below displays the results for Lead Screening in Children by MCO.

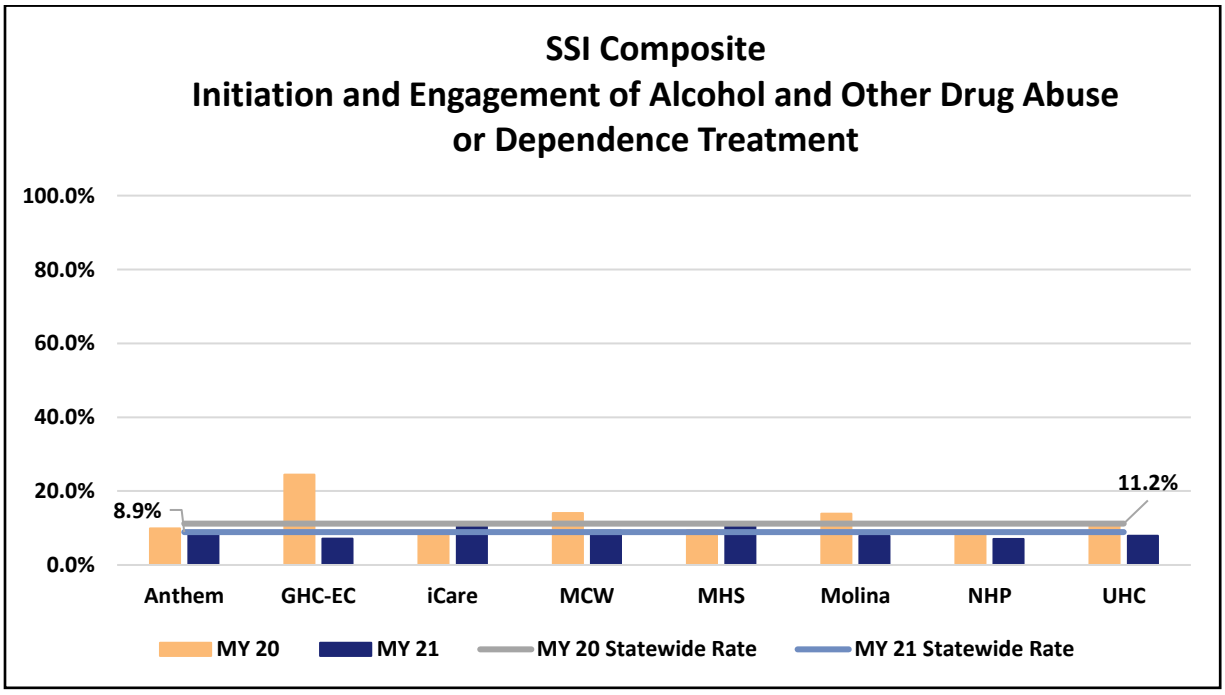


SSI Composite Measures

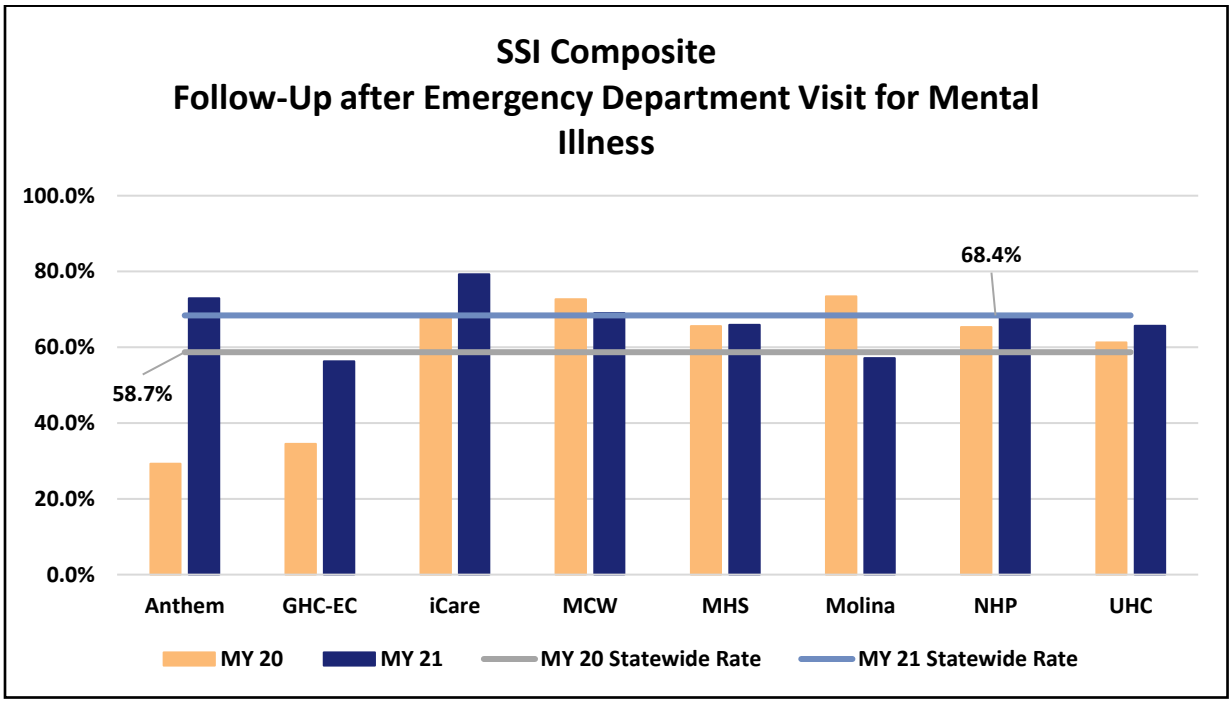
The following graph displays the results for Controlling Blood Pressure by MCO.



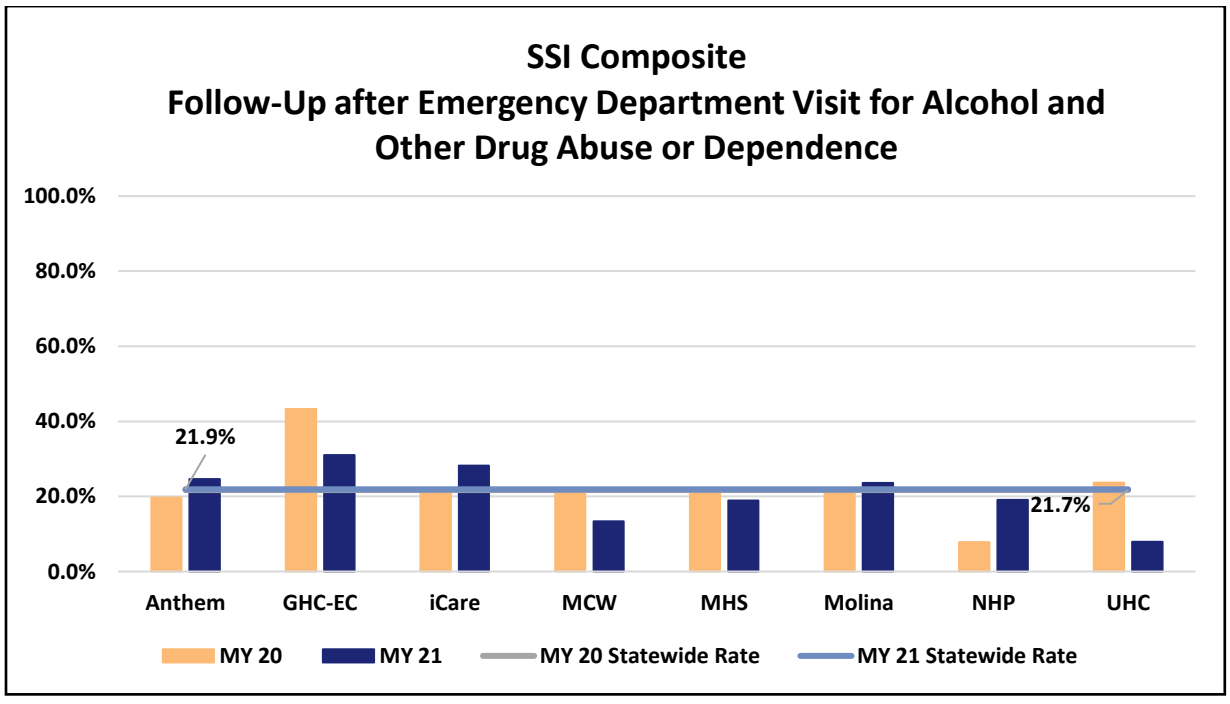
The graph below displays the results for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment by MCO.



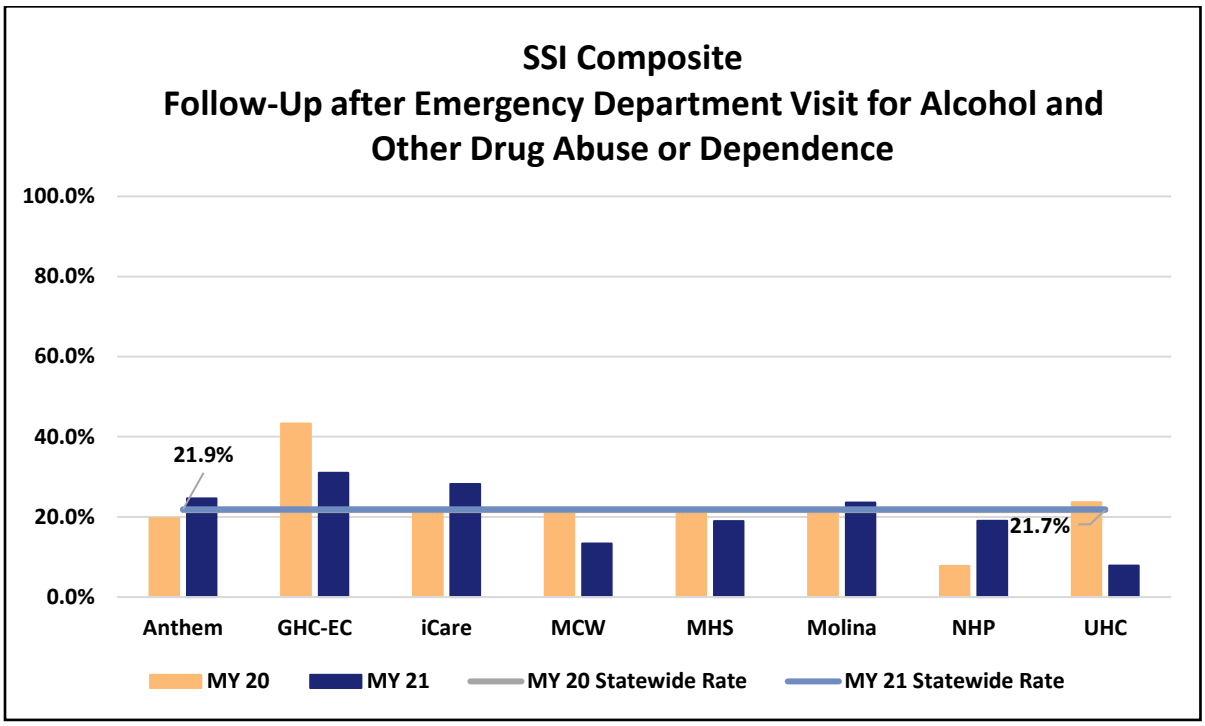
The graph below displays the Follow-Up after Emergency Department Visit for Mental Illness by MCO.



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.



CONCLUSIONS

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

PROTOCOL 3: COMPLIANCE WITH STANDARDS

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

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

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 review is divided into three groups of standards:

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

- Enrollee rights and protections 42 CFR 438.100
- Availability of services 42 CFR 438.206
- Assurances of adequate capacity and services 42 CFR 438.207
- Coordination and continuity of care 42 CFR 438.208

- Coverage and authorization of services 42 CFR 438.210
- Provider selection 42 CFR 438.214
- Confidentiality 42 CFR 438.224
- Subcontractual relationships and delegation 42 CFR 438.230
- Practice guidelines 42 CFR 438.236
- Health information systems 42 CFR 438.242

Quality Assessment and Performance Improvement (QAPI):

- Quality assessment and performance improvement program 42 CFR 438.330

Grievance Systems:

- Grievance and appeal systems 42 CFR 438.228

Overall Compliance Results by MCO

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

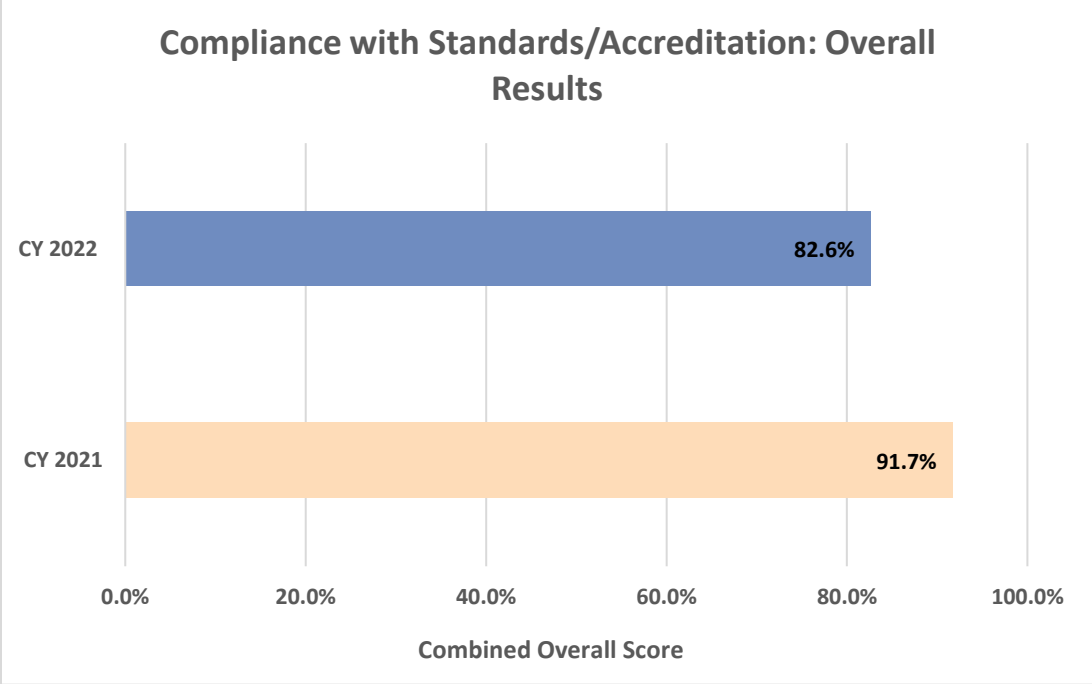
Scoring Legend	
Percentage Met	**Rating**
90.0% - 100.0%	Excellent
80.0% - 89.9%	Very Good
70.0% - 79.9%	Good
60.0% - 69.9%	Fair
< 60.0%	Poor

MetaStar conducted one Compliance with Standards review during CY 2022 for one MCO that was not accredited by NCQA. During CY21 MetaStar conducted 11 accreditation desk reviews for MCOs holding NCQA Accreditation. No accreditation desk reviews were conducted in CY 2022. The following graphs indicate the MCO's overall level of compliance in the CY 2022 Compliance with Standards review.

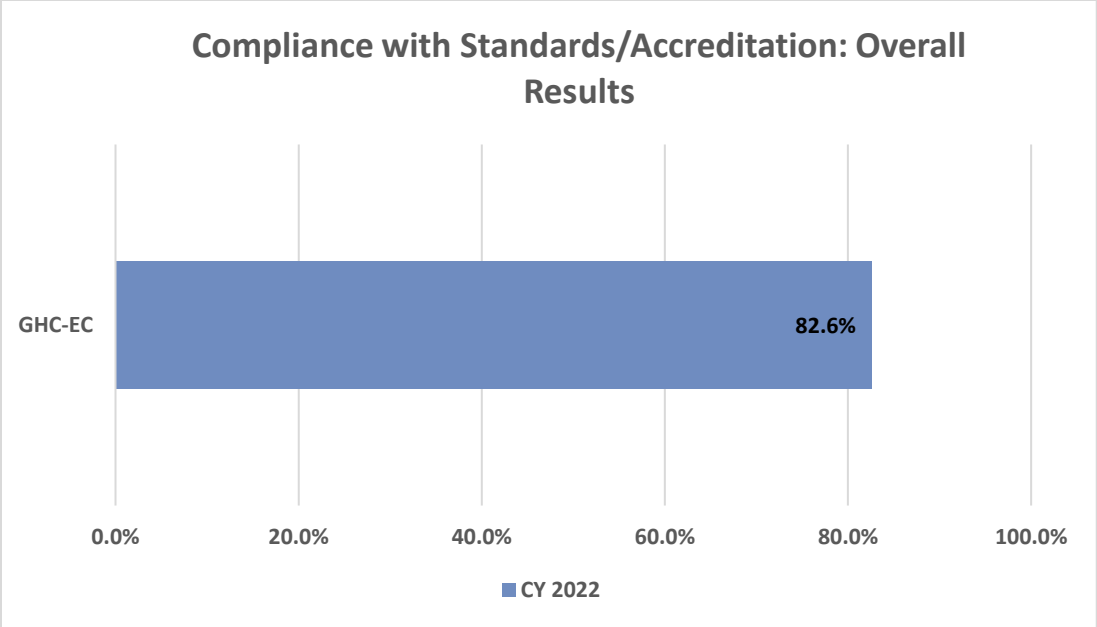
For the MCO reviewed, the statewide overall compliance score is 82.6 percent, and a rating of Very Good. The table below indicates the overall level of compliance with each one of the focus areas of standards comprising the Compliance with Standards review in this reporting period.

MCO Compliance with Standards Review CY 2022			
Focus Area	**Scoring Elements**	**Percentage**	**Rating**
MCO Standards	84/93	90.3%	Excellent
QAPI	15/16	93.8%	Excellent
Grievance Systems	29/46	63.0%	Fair
Overall	**128/155**	**82.6%**	**Very Good**

The graph below illustrates the State's overall compliance with these standards in CY 2022 and compares the score to the same standards reviewed in CY 2021.



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



The definition of a scoring element rated as compliant can be found in Appendix 2 which includes the full implementation of written policies and procedures, education of relevant staff, and sufficient monitoring. MetaStar uses a retrospective review period of 12 months prior to each MCO's 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.

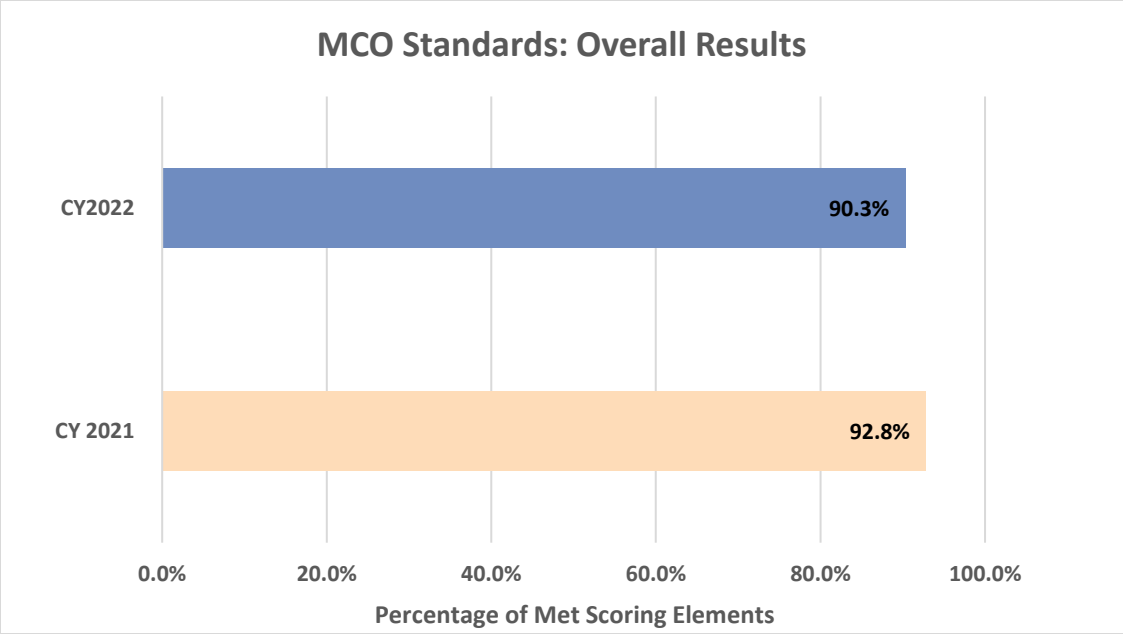
MCOs are also responsible to help members understand their rights as well as to ensure those rights are protected. This requires an adequate organizational structure and sound processes that adhere to federal and state requirements, and are capable of ensuring that members' rights are protected.

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

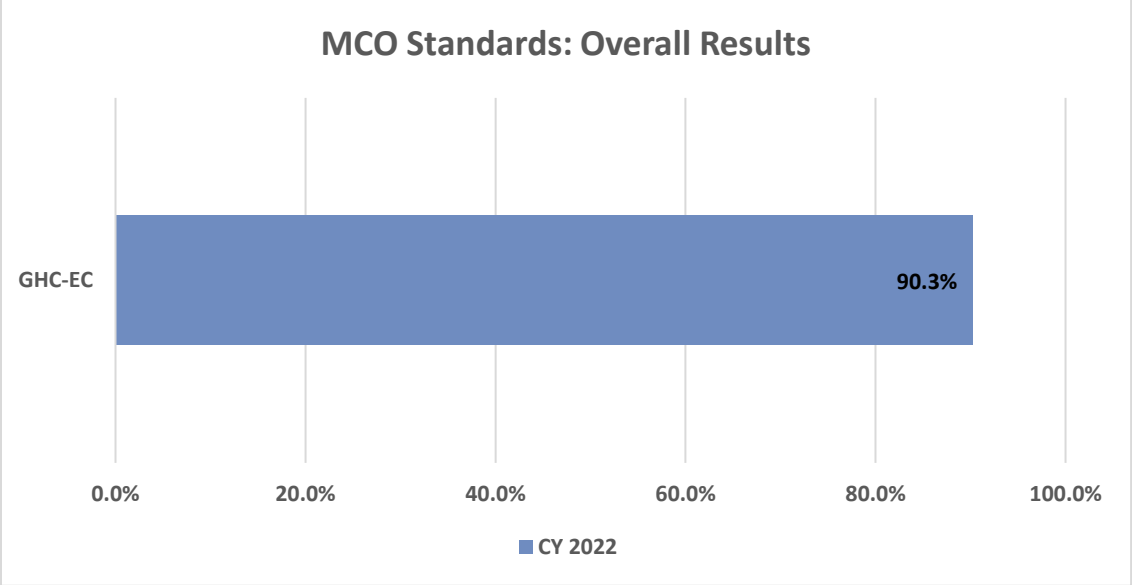
MCO Standards: Provider Network, Care Management, and Enrollee Rights CY 2022			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M1	7/7	100.0%	Excellent
M2	7/7	100.0%	Excellent
M3	3/3	100.0%	Excellent
M4	7/7	100.0%	Excellent
M5	6/6	100.0%	Excellent
M6	7/7	100.0%	Excellent
M7	10/10	100.0%	Excellent
M8	6/8	75.0%	Good
M9	9/11	81.8%	Very Good
M10	2/3	66.7%	Fair
M11	1/4	25.0%	Poor
M12	1/1	100.0%	Excellent
M13	10/11	90.9%	Excellent
M14	5/5	100.0%	Excellent
M15	3/3	100.0%	Excellent
M16*	NA	NA	NA
Overall	**84/93**	**90.3%**	**Excellent**

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

The graph on the next page illustrates the State's overall compliance with this focus area in CY 2022 and compares the score to the same focus area reviewed in CY 2021.



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



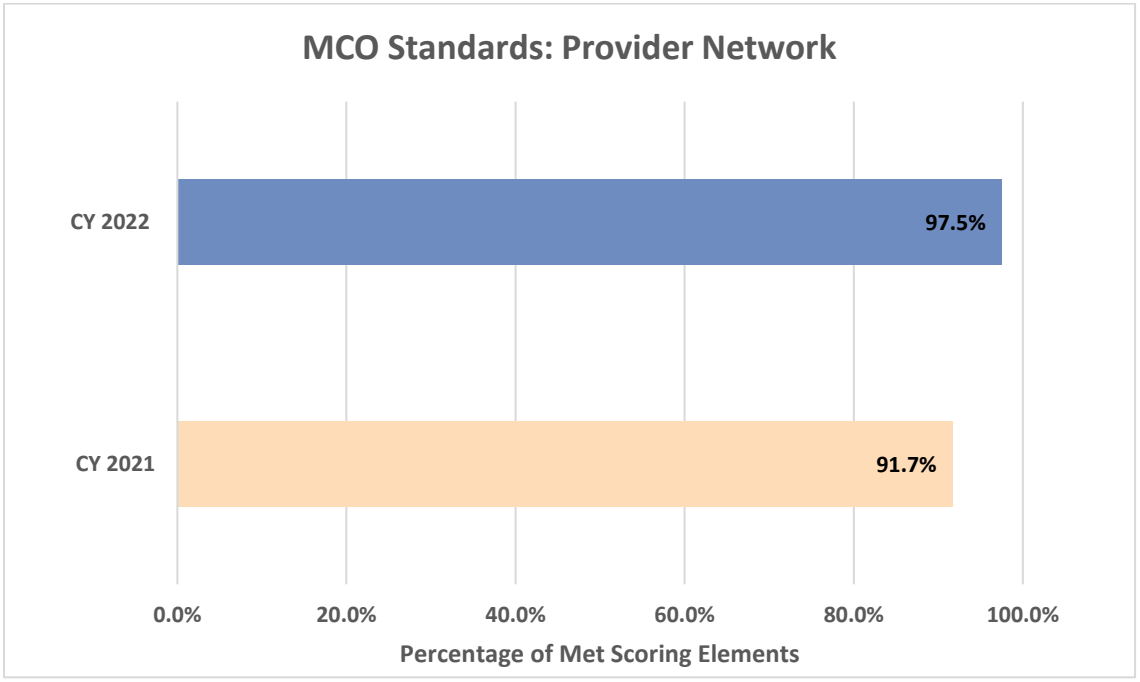
Observation and Analysis: MCO Standards, Provider Network

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

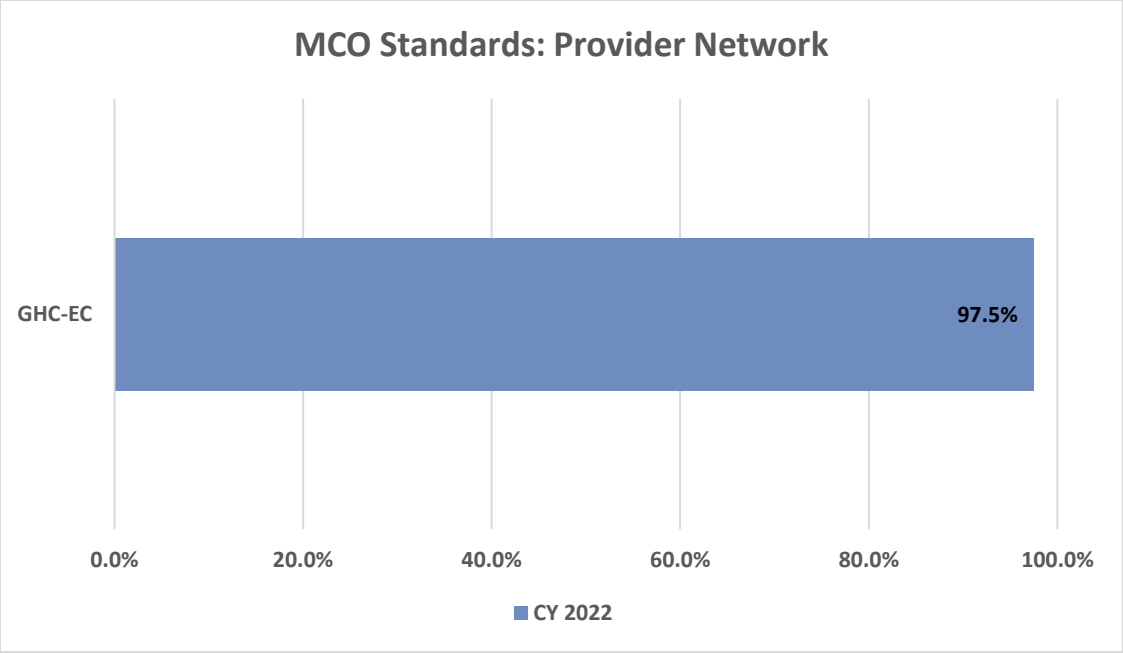
selection, sub-contractual/provider relationships, and delegation. The table below indicates the MCO's compliance with these standards.

MCO Standards: Provider Network CY 2022			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M1	7/7	100.0%	Excellent
M2	7/7	100.0%	Excellent
M3	3/3	100.0%	Excellent
M4	7/7	100.0%	Excellent
M13	10/11	90.9%	Excellent
M14	5/5	100.0%	Excellent
Overall	**39/40**	**97.5%**	**Excellent**

The graph below illustrates the State's overall compliance with this focus area in CY 2022 and compares the score to the same focus area reviewed in CY 2021.



The following graph illustrates the MCO's 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. The MCO satisfied requirements for seven out of seven scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The organization's policies and procedures included a detailed process to ensure network adequacy. Document submission and the staff interview demonstrated the implementation of these practices.

M2 Timely access to services - 42 C.F.R. 438.206(c)(1)

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

The organization's policies and procedures included the required elements of this standard. The organization utilized internal reporting to demonstrate monitoring providers for compliance.

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

The MCOs must participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic background, disabilities, and regardless of sex. The standard, M3, contains three scoring elements. The MCO satisfied requirements for three out of three scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The organization demonstrated efforts to promote the delivery of services in a culturally competent manner to all members. The MCO's policies and procedures included provider expectations for cultural competency.

M4 Network adequacy - 42 CFR 438.207

The MCOs must ensure its delivery network is sufficient to provide adequate access to all services. The standard, M4, contains seven scoring elements. The standard, M4, contains seven scoring elements. The MCO satisfied requirements for seven out of seven scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The MCO's internal reporting and the staff interview session confirmed the organization utilizes various methods and tools for maintaining and monitoring the provider network.

M13 Provider selection - 42 CFR 438.214

The MCOs must have a written process for the selection and periodic evaluation of qualified providers. The MCOs are responsible for ensuring all applicable provider requirements are met at initial contracting and throughout the duration of the contract. The standard, M13, contains 11 scoring elements. The MCO satisfied requirements for 10 out of 11 scoring elements, for a score of 90.9 percent, and a rating of Excellent.

The MCO's documents satisfied most elements of this standard. The MCO's policies and procedures defined the organization's selection and retention process, including the process to recredential providers every three years, at a minimum. Additional MCO documents support the processes are in place.

M14 Subcontractual relationships and delegation - 42 CFR 438.230

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

The MCO's documents and the staff interview session demonstrated the organization's compliance of this standard including the use of risk management tools to aid in oversight of provider responsibilities.

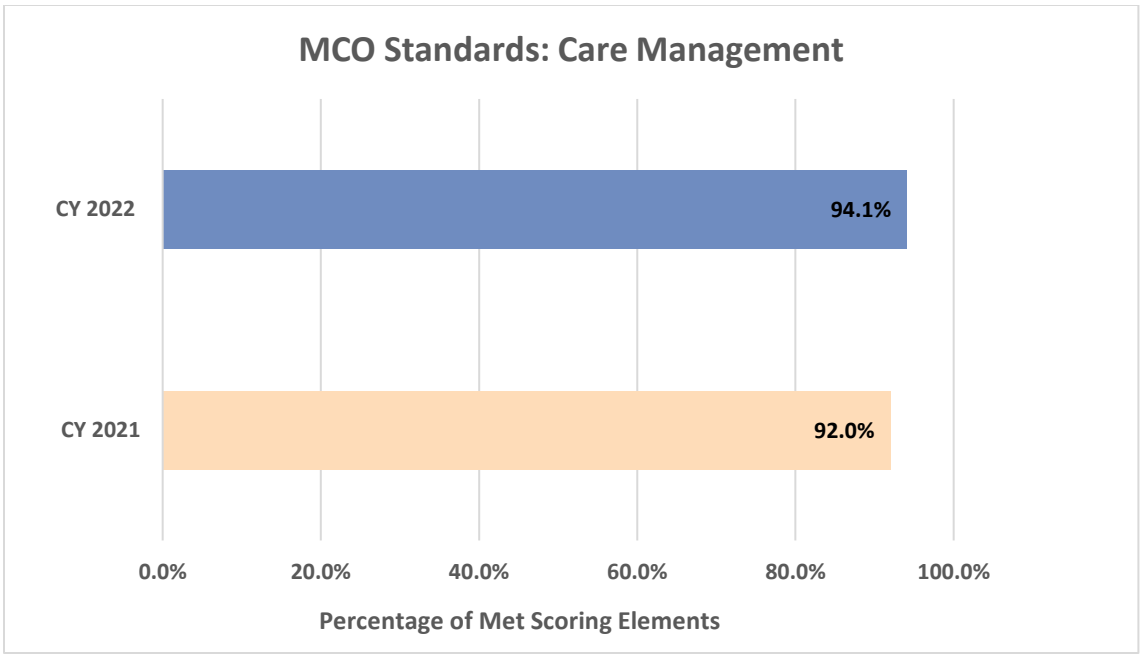
Observation and Analysis: MCO Standards, Care Management

MCOs must provide members timely access to high quality long-term care and health care services by developing and maintaining the structure, operations, and processes to ensure coordination and continuity of member care, timely authorization of services, and issuance of notices to members. Five standards address requirements related to coordination and continuity of care, and coverage and authorization of services. The table below indicates the MCO's compliance with these standards.

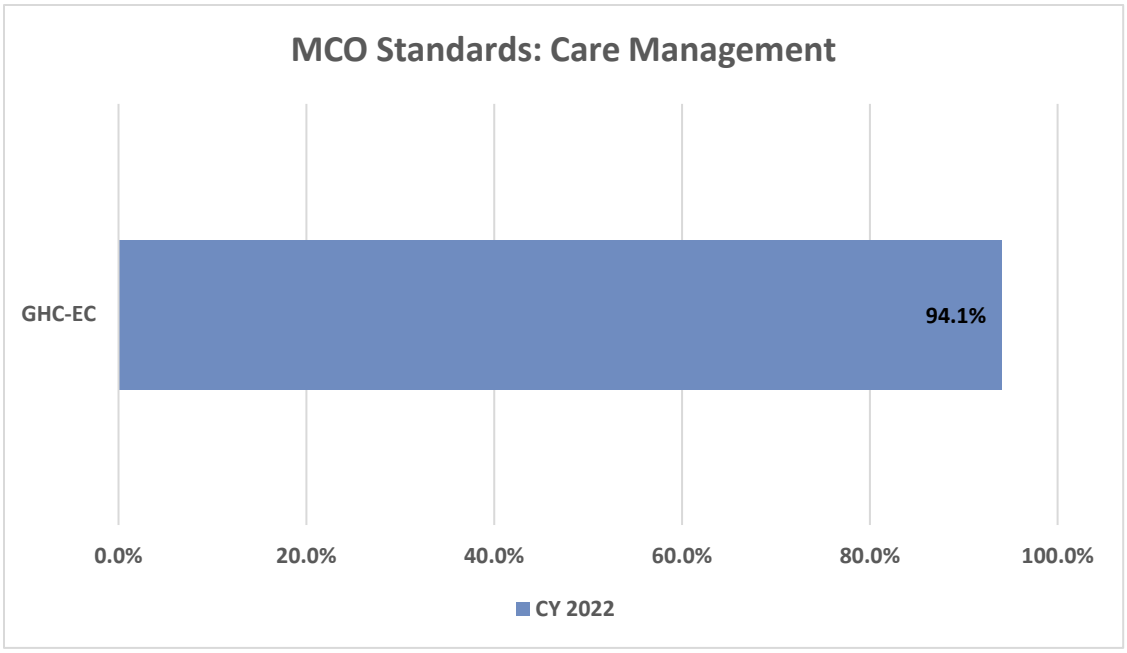
MCO Standards: Care Management CY 2022			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M5	6/6	100.0%	Excellent
M6	7/7	100.0%	Excellent
M7	10/10	100.0%	Excellent
M8	6/8	75.0%	Good
M15	3/3	100.0%	Excellent
M16*	NA	NA	N/A
Overall	**32/34**	**94.1%**	**Excellent**

* 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 on the next page illustrates the State's overall compliance with this focus area in CY 2022 and compares the score to the same focus area reviewed in CY 2021.



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



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

Two standards address requirements related to coordination and continuity of care. Both standards address the requirement to maintain the confidentiality of member information. The MCOs must implement procedures to deliver care to and coordinate services for all MCO members (M5). The standard, M5, contains six scoring elements. The MCO satisfied requirements for six out of six scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The MCO's documents outlined detailed processes and expectations for the coordination of member care, including ensuring the protection of member information between providers and programs during care coordination.

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

The MCO's policies and procedures defined the expectations for member assessment and care planning, including detailed information on members' needs level and the corresponding care planning steps based on those needs. During the interview session, staff discussed the MCO's approach to care management, including ongoing monitoring to ensure care management staffing levels are adequate to respond to members with the highest needs.

M7 Disenrollment: requirements and limitations - 42 CFR 438.56

The MCOs must comply with requirements for member disenrollment. The standard, M7, contains 10 scoring elements. The MCO satisfied requirements for 10 out of 10 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The documents submitted included all required elements of 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

MCO policies and procedures for service authorizations must comply with required standards. The standard, M8, contains eight scoring elements. The MCO satisfied requirements for six out of eight scoring elements, for a score of 75.0 percent, and a rating of Good.

The MCO's documents included requirements for timely service authorizations. Four scoring elements of this standard relate to emergency and post-stabilization of services. The documents submitted outline many of these responsibilities; however, not all required criteria were included.

Scoring element M8.5 indicates the MCO is responsible for coverage and payment of emergency services and post stabilization care services. The scoring element includes circumstances that the MCO may not deny payment for treatment obtained, which includes when a representative of the MCO instructs the enrollee to seek emergency services. This circumstance is not included in the MCO's policies submitted for review. MetaStar recommends the MCO include all circumstances under which the MCO may not deny payment for treatment obtained in written policies and procedures.

Scoring element M8.6 indicates the MCO may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, or MCO of the member's screening and treatment within 10 calendar days. These criteria are not included in the documents submitted for review. MetaStar recommends the MCO include all required criteria in written guidance.

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

The MCO's documents specified that practice guidelines are used for prevention and wellness services for members, are developed with current evidence, and reviewed and updated periodically, and are available on the MCO's website.

M16 Health information systems – 42 CFR 438.242

The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment, for other than loss of Medicaid eligibility. This standard is evaluated as part of the MCO's Information Systems Capability Assessment (ISCA), conducted once every three years. The ISCA occurs separate from the Compliance review.

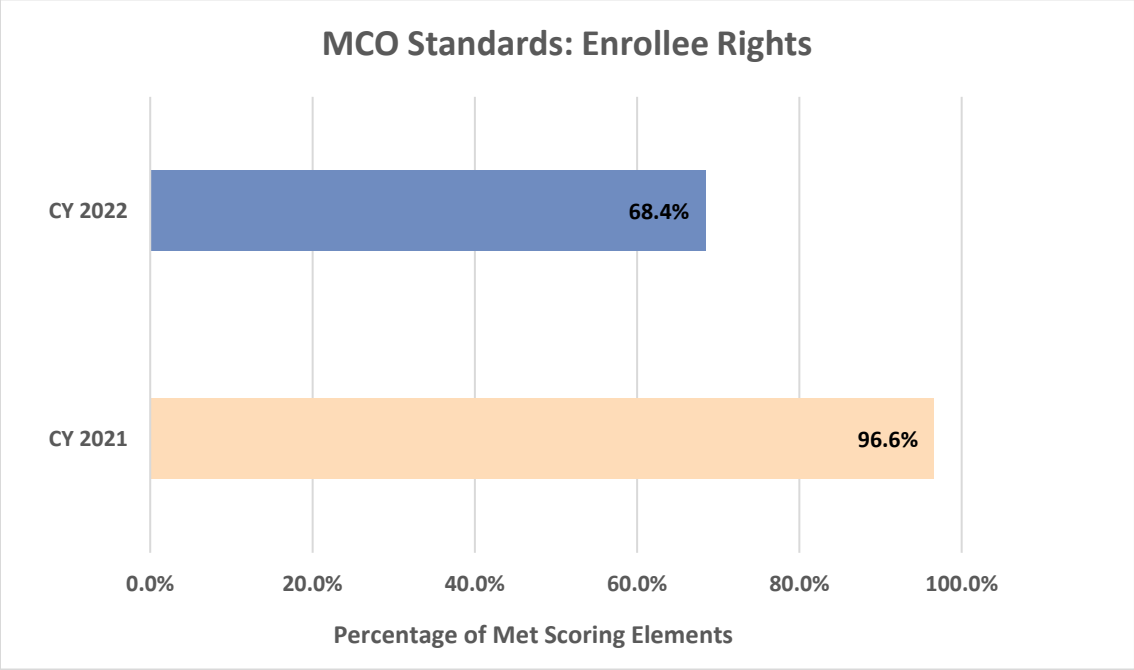
Observation and Analysis: MCO Standards, Enrollee Rights

MCOs are responsible to help members understand their rights as well as to ensure those rights are protected. This requires an adequate organizational structure and sound processes that adhere to federal and state requirements and ensure that members' rights are protected. Four standards comprise this review focus area. The standards in this area of review address members' general

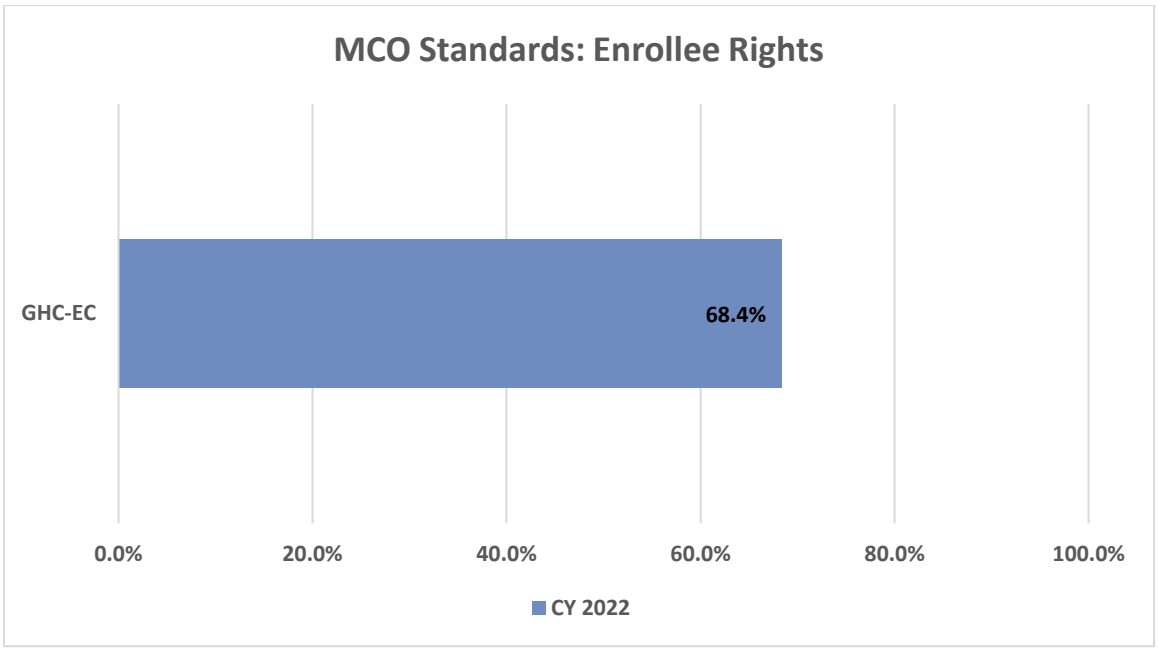
rights, such as the right to information, as well as a number of specific rights, such as those related to dignity, respect, and privacy. The table below indicates the MCO's compliance with these standards.

MCO Standards: Enrollee Rights CY 2022			
Standard	**Scoring Elements**	**Percentage**	**Rating**
M9	9/11	81.8%	Very Good
M10	2/3	66.7%	Fair
M11	1/4	25.0%	Poor
M12	1/1	100.0%	Excellent
Overall	**13/19**	**68.4%**	**Fair**

The graph below illustrates the State's overall compliance with this focus area in CY 2022 and compares the score to the same focus area reviewed in CY 2021.



The graph on the next page illustrates the MCO's overall compliance with this focus area.



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

Organizations are required to provide readily accessible written information to members in a manner and format that is easily understood. The standard, M9, contains 11 scoring elements. The MCO satisfied requirements for nine out of 11 scoring elements, for a score of 81.8 percent, and a rating of Very Good.

The MCO posts the current member handbook and provider directory on their website and notifies all members annually that these materials are available online and that the member can be mailed a hard copy upon request. The documents submitted ensure all member materials are written for ease of understanding and are provided in alternate formats and languages as required, including auxiliary aids and the use of oral interpretation services.

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. The MCO satisfied requirements for two out of three scoring elements, for a score of 66.7 percent, and a rating of Fair.

The MCO's policies and procedures specified members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the members condition and ability to understand.

Scoring element M10.2 states MCOs may not prohibit or restrict providers acting within their lawful scope of practice from advising or advocating on behalf of a member, including any of the following:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

The MCO's subcontract informs providers of their right to explore all treatment options with the member. MetaStar recommends the MCO update its written guidance to include all of the specific requirements for staff and provider information.

Scoring element 10.3 states the MCO must provide members with the opportunity to choose a primary care provider affiliated with the MCO, including culturally appropriate care. In difficult case management situations, the MCO must submit a written request to the MCO's managed care analyst, in advance of a lock-in request of a member to one primary provider. No documentation was submitted outlining the primary provider lock-in guidelines. MetaStar recommends the MCO update its written guidance to include information regarding the primary provider lock-in guidelines.

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

MCOs will have written policies and procedures for member rights and advance directives, which include the right to participate in decisions regarding his or her care, the right to refuse treatment. The standard, M11, contains four scoring elements. The MCO satisfied requirements for one out of four scoring elements, for a score of 25.0 percent, and a rating of Poor.

In addition to having member rights policies, members also have specific rights while enrolled in the SSI/BC+ program. The MCO's documents submitted met some of the requirements of this standard.

Scoring element M11.1 requires the MCO share those written member rights policies with staff and affiliated providers. Staff interviews confirmed the member rights policy is reviewed as part

of their training. New providers receive member rights information but the member rights policy is not given to providers as required. MetaStar recommends the MCO revise its process to give the member rights policy to providers as required.

Scoring element M11.2 requires MCOs to have written restraint policies guaranteeing each member's right to be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation. The MCO does not have a restraint policy as required. MetaStar recommends the MCO develop and implement a restraint policy.

Scoring element 11.4 requires MCOs to have written policies and procedures for advance directives which include all requirements. The MCO's policy met most of the requirements. The policy did not include:

- Clarify any differences between any MCO conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives.
- Describe the range of medical conditions or procedures affected by the conscience objection.

MetaStar recommends the MCO revise its policy to include all required language.

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

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

The MCO's documents and the staff interview session met the requirements of this standard to ensure staff and provider interactions with members demonstrate dignity and respect at all times.

OBSERVATION AND ANALYSIS: QAPI STANDARDS

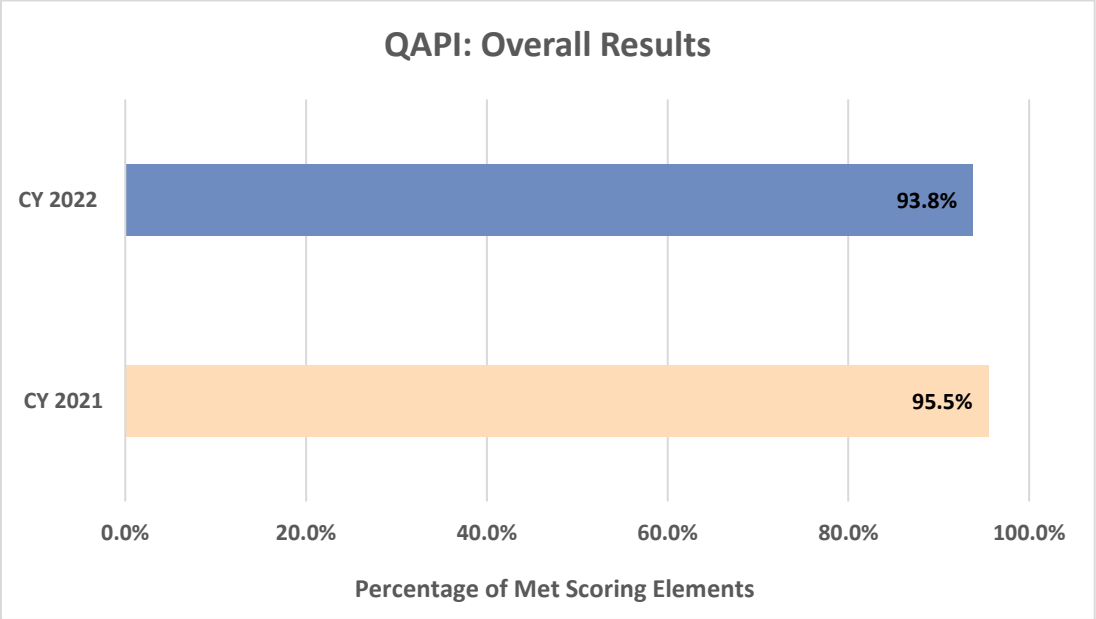
MCOs are required to have a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports. Five standards address the requirements related to the Quality Management program. Two standards, Q3 and Q4, are evaluated as part of the MCO's performance measure validation and performance improvement project validation, which occur separate from the QCR. The table below indicates the MCO's compliance with these standards.

Quality Assessment and Performance Improvement Standards CY 2022			
Standard	**Scoring Elements**	**Percentage**	**Rating**
Q1	9/9	100.0%	Excellent
Q2	5/6	83.3%	Very Good
Q3*	NA	NA	NA
Q4*	NA	NA	NA

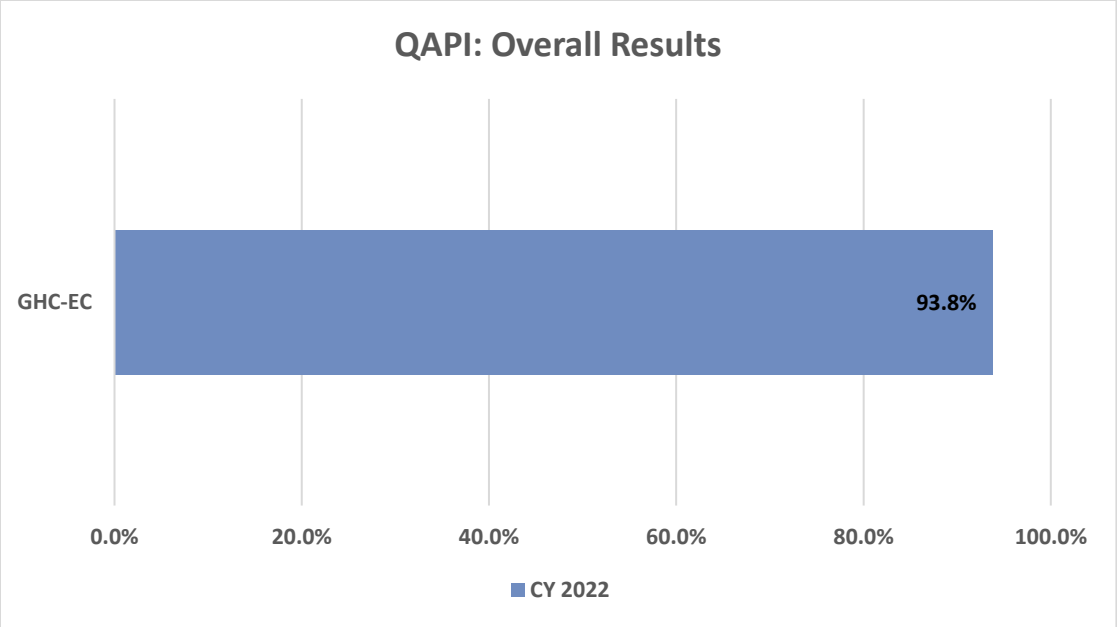
Quality Assessment and Performance Improvement Standards CY 2022			
Standard	**Scoring Elements**	**Percentage**	**Rating**
Q5	1/1	100.0%	Excellent
Overall	**15/16**	**93.8%**	**Excellent**

*Q3 and Q4 are evaluated as part of the organization's performance measure validation and performance improvement project validation. These reviews occur separate from the Compliance with Standards review.

The graph below illustrates the State's overall compliance with this focus area in CY 2022 and compares the score to the same focus area reviewed in CY 2021.



The graph on the next page illustrates the MCO's overall compliance with this focus area.



Q1 General rules - 42 CFR 438.330(a)

The MCOs' quality management programs shall be administered through clear and appropriate structures, and include member, staff, and provider participation. The standard, Q1, contains nine scoring elements. The MCO satisfied requirements for nine out of nine scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The MCO has a quality management program with sound structures that facilitate participation from staff and providers. Practices were evidenced through meeting minutes and interview sessions with MCO staff.

Q2 Basic elements of the quality assessment and performance improvement program - 42 CFR 438.330(b)

The MCOs shall maintain documentation and monitoring of the required activities of the Quality Management program. The standard, Q2, contains six scoring elements. The MCO satisfied requirements for five out of six scoring elements, for a score of 83.3 percent, and a rating of Very Good.

The organization's Quality Management Program included the required monitoring activities. The staff interview detailed a variety of ways that data is used throughout the organization to monitor the quality of care and make informed decisions.

Q3 Performance measurement - 42 CFR 438.330(c)

These requirements are evaluated through the Performance Measure Validation activity, which is conducted on a different cycle than the QCR.

Q4 Performance improvement projects - 42 CFR 438.330(d)

These requirements are evaluated through the Performance Improvement Project (PIP) activity, which is conducted on a different cycle than the QCR.

Q5 QAPI evaluations review - 42 CFR 438.330(e)(2)

MCOs create and evaluate the quality work plan annually. The standard, Q5, contains one scoring element. The MCO satisfied requirements for this scoring element, for a score of 100.0 percent, and a rating of Excellent.

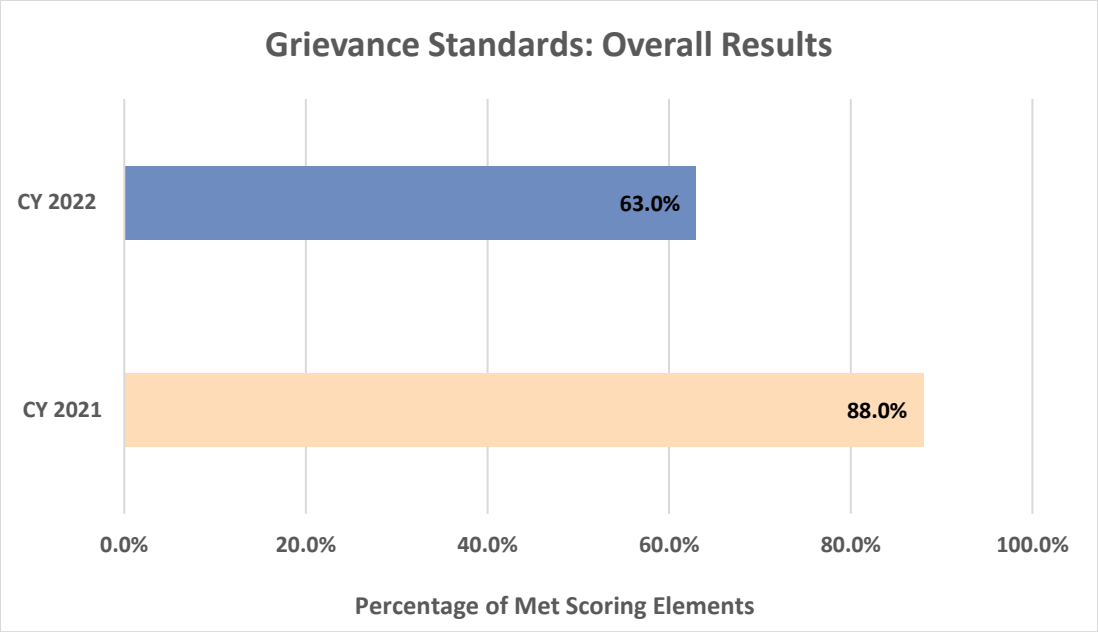
The MCO's documents demonstrated a process for evaluating the work plan annually and the staff interview confirmed these practices. The results of the prior QAPI plan are utilized in the development of the current plan.

Observation and Analysis: Grievance Systems

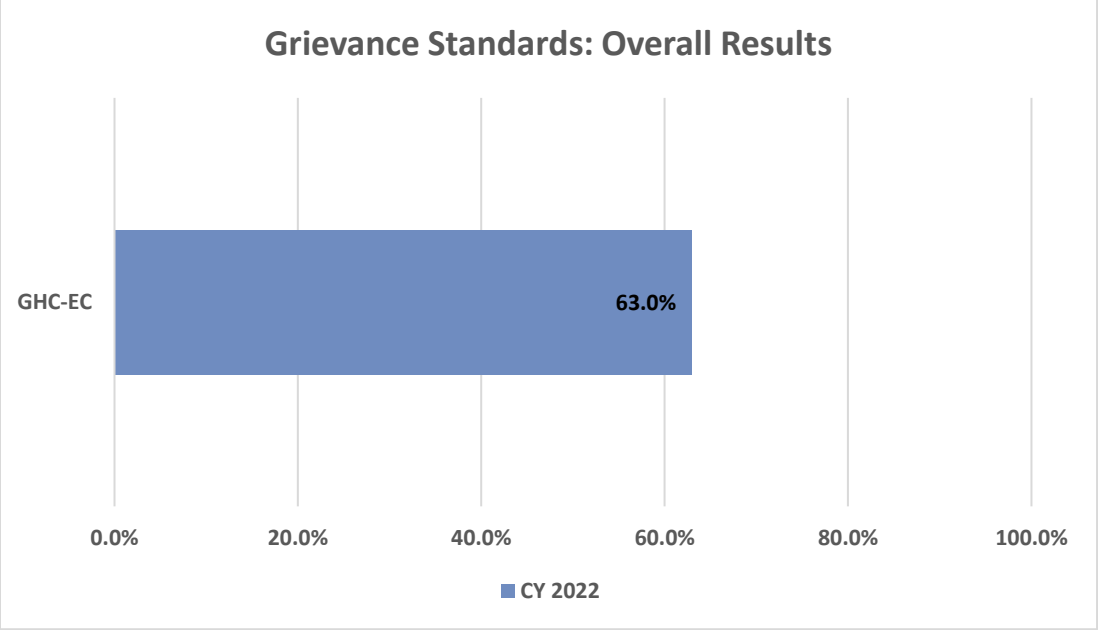
MCOs are required to maintain a grievance system that provides members the ability to grieve or appeal actions of the organization and provides access to the State's Fair Hearing system. Ten standards address the requirements related to the required grievance systems. The table below indicates the MCO's compliance with these standards.

Grievance Systems Standards CY 2022			
Standard	**Scoring Elements**	**Percentage**	**Rating**
G1	4/5	80.0%	Very Good
G2	7/7	100.0%	Excellent
G3	1/7	14.3%	Poor
G4	1/2	50.0%	Poor
G5	11/13	84.6%	Very Good
G6	1/3	33.3%	Poor
G7	0/1	0.0%	Poor
G8	2/2	100.0%	Excellent
G9	2/4	50.0%	Poor
G10	0/2	0.0%	Poor
Overall	**29/46**	**63.0%**	**Fair**

The graph on the next page illustrates the State's overall compliance with this focus area in CY 2022 and compares the score to the same focus area reviewed in CY 2021.



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



G1 Grievance systems - 42 CFR 438.228

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. The standard, G1,

contains five scoring elements. The MCO satisfied requirements for four out of five scoring elements, for a score of 80.0 percent, and a rating of Very Good.

The MCO's documents confirmed systems are in place for grievances and appeals. This includes attempts to resolve issues and ensure required timeframes are met.

G2 General requirements - 42 CFR 438.402

MCOs must adhere to requirements for the member's authority, process, and timing to file grievances and appeals. The standard, G2, contains seven scoring elements. The MCO satisfied requirements for seven out of seven scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The MCO's documents and the staff interview session met the requirements of this standard for authority, process, and timing for filing grievances and appeals.

G3 Timely and adequate notice of adverse benefit determination - 42 CFR 438.404

MCOs must comply with content requirements and timing of *Notices of Adverse Benefit Determination*. The standard, G3, contains seven scoring elements. The MCO satisfied requirements for one out of seven scoring elements, for a score of 14.3 percent, and a rating of Poor.

The notice template submitted met the content requirements and is approved by DHS.

MCOs must mail the notice within specified timeframes associated with each type of adverse decision. The documents submitted did not include guidance for the timing requirements for issuing notices in the following scoring elements:

- Scoring element G3.2 identifies the circumstances and timeframes for issuing notices for termination, suspension, or reduction of previously authorized Medicaid-covered services.
- Scoring element G3.3 requires notices to be issued for the denial of payment affecting a claim.
- Scoring element G3.4 requires notices to be issued for decisions that deny or limit services.
- 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.
- Scoring element G3.6 requires notices to be issued for service authorization decisions not reached within the specified timeframes.

- Scoring element G3.7 requires notices to be issued for expedited service authorization decisions, as expeditiously as the member's health condition requires and no later than 72 hours after the receipt of the request for service.

MetaStar recommends the MCO revise its written guidance, policies, and procedures to include timeframe requirements for all circumstances.

G4 Handling of grievances and appeals - 42 CFR 438.406

MCOs must comply with requirements for handling of grievances and appeals, including acknowledgement, local committee composition and requirements, and special requirements for appeals. The standard, G4, contains two scoring elements. The MCO satisfied requirements for one out of two scoring elements, for a score of 50.0 percent, and a rating of Poor.

The MCO's documentation indicated the organization's Member Advocate provides assistance to member in navigating the MCO's grievance and appeals process. Additionally, the Member Advocate ensures the receipt of grievances and appeals are sent to members and are established at the earliest filing date.

Scoring element G4.2 outlines the requirements for the committee composition. The documents submitted state the committee includes varying staff members, including at least one individual authorized to take corrective action and the staff member making the original decision will not be a part of the committee, or have a direct subordinate of the staff member who made the original denial decision. In addition, the MCO is to ensure that the individuals who make decisions on grievances and appeals are individuals:

- Who are health care professionals with appropriate clinical expertise, if deciding any of the following:
    - An appeal of a denial that is based on lack of medical necessity.
    - A grievance regarding denial of expedited appeal resolution.
    - A grievance or appeal that involves clinical issues.
- Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

These requirements are not included in the policy or other documents submitted. MetaStar recommends the MCO revise its written guidance to include all requirements regarding the committee structure and composition.

G5 Resolution and notification - 42 CFR 438.408

MCOs must comply with requirements for the resolution and notification requirements for grievances and appeals. The standard, G5, contains 13 scoring elements. The MCO satisfied

requirements for 11 out of 13 scoring elements, for a score of 84.6 percent, and a rating of Very Good.

The MCO's documents and the staff interview session confirmed compliance with most of the requirements of this standard. Systems are in place for resolving and notifying members in writing within required timeframes.

G6 Expedited resolution of appeals - 42 CFR 438.410

MCOs must comply with requirements for an expedited review process for appeals. The standard, G6, contains three scoring elements. The MCO satisfied requirements for one out of three scoring elements, for a score of 33.3 percent, and a rating of Poor.

The MCO's documents identified an expedited review process for resolving appeals within 72 hours of the request.

Scoring element G6.2 states the MCO must ensure that punitive action is not taken against anyone who requests an expedited resolution or supports a member's appeal. No documents were submitted to fulfill this requirement. MetaStar recommends the MCO revise its guidance to include that punitive action is not taken against anyone who requests an expedited resolution or supports a member's appeal.

Scoring element G6.3 identifies if the MCO denies a request for an expedited review, it must transfer the appeal in the standard resolution timeframe and notify the member of the reason for the denial. The MCO did not submit a written process to notify members of the decision to deny their request for an expedited resolution of an appeal. MetaStar recommends the MCO develop and implement a process to notify members in writing of the decision to deny a request for an expedited resolution of an appeal.

G7 Information about grievance and appeal system to providers and subcontractors - 42 CFR 438.414

MCOs must provide information about the grievance and appeal system to providers and subcontractors. The standard, G7, contains one scoring element. The MCO did not satisfy requirements for this scoring element, for a score of 00.0 percent, and a rating of Poor.

The MCO's subcontract includes this information. Scoring element G7.1 requires that the *Ombudsmen Brochure* and *HMO* and *PIHP Grievances and Appeals Guide* be distributed to providers at the time the contract is entered. Staff interviews confirmed this information is not given to providers. MetaStar recommends the MCO develop and implement a process to ensure this information is distributed within specified timeframes to all providers and subcontractors.

G8 Record keeping requirements - 42 CFR 438.416

MCOs must comply with record keeping requirements for grievances and appeals. The standard, G8, contains two scoring elements. The MCO satisfied requirements for two out of two scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The documents submitted and interview sessions met the requirements of this standard.

G9 Continuation of benefits while the local appeal and the state Fair Hearing are pending - 42 CFR 438.420

MCOs must comply with requirements for continuation of benefits, duration, and member responsibility for costs. The standard, G9, contains four scoring elements. The MCO satisfied requirements for two out of four scoring elements, for a score of 50.0 percent, and a rating of Poor.

The MCO's documents included information about members needing to request benefits continue within timeframes and that members may be liable for the cost of services if the final decision is adverse to the member.

Scoring elements G9.2 and G9.3 outline the criteria for continuing and for ending benefits during an appeal. No written guidance was submitted to ensure these practices are in place. MetaStar recommends the MCO revise its written guidance to include these requirements.

G10 Effectuation of reversed appeal resolution - 42 CFR 438.424

If an 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. The MCO satisfied requirements for zero out of two scoring elements, for a score of 00.0 percent, and a rating of Poor.

Scoring element G10.1 requires the MCO 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 MCO's initial denial, limitation, or delay of services. The staff interview described the process to correct or update the authorization within 24 hours and having up to 72 hours if needed. The documents submitted did not include this information. MetaStar recommends the MCO update its written guidance to include the effectuation of reversed appeal resolutions.

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. No written guidance was submitted to ensure these practices are in place. MetaStar recommends the MCO update its written guidance to include this requirement.

Protocol 9: Conducting Focused Studies of Health Care Quality – Care Management Review – Supplemental Security Income

Care management review (CMR) is an optional activity, *CMS External Quality Review (EQR) Protocols, Protocol 9: Conducting Focus Studies of Health Care Quality*, which determines a MCO's level of compliance with the DHS-MCO contract. The information gathered during CMR helps assess the access, timeliness, quality, and appropriateness of care an MCO provides to its members.

Following the FY 20-21 care management review, the review was paused for FY 21-22 at the request of DHS in order to realign review criteria with the DHS-MCO contract. DHS held stakeholder meetings and solicited feedback from MetaStar and the MCOs that operate the program to evaluate the clarity of review requirements.

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 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. The FCMH review provides an evaluation of the Medical Home provider's compliance with DHS requirements for the optional Medicaid benefit, and an assessment of its required care coordination systems.

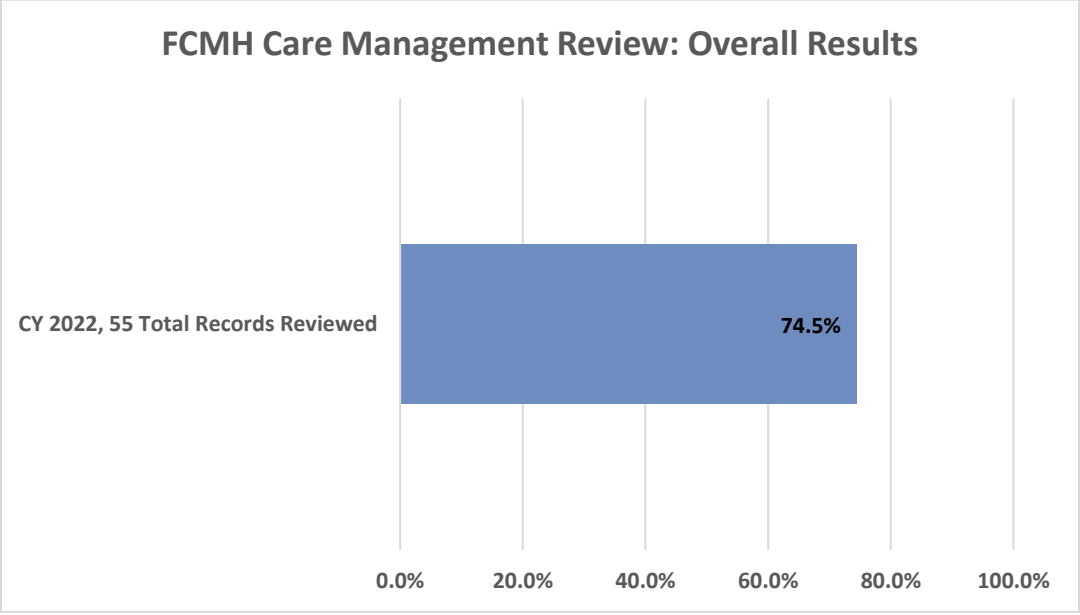
The review focused on five categories to evaluate program compliance:

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

The five categories included a total of 13 review indicators. More information about the review methodology can be found in Appendix 2.

Overall Results

The bar graph below represents the overall percent of CMR standards met by the PIHP in FY 22-23 for all 13 review indicators.



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

Observations and Analysis for each CMR Focus Area

Each of the five sub-sections below provides a brief explanation of a key CMR category, followed by bar graphs which display CY 2022 results for each indicator that comprises the category. Following the FY 21-22 care management review, the review was revised at the request of DHS. Results from the previous review are not comparable.

Observations and Analysis: Screening

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

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

The OHC Health Screen must be communicated with those involved in the care and treatment of the child. The PIHP is responsible for conducting follow-up activities for immediate or emergent needs uncovered during the OHC screen.

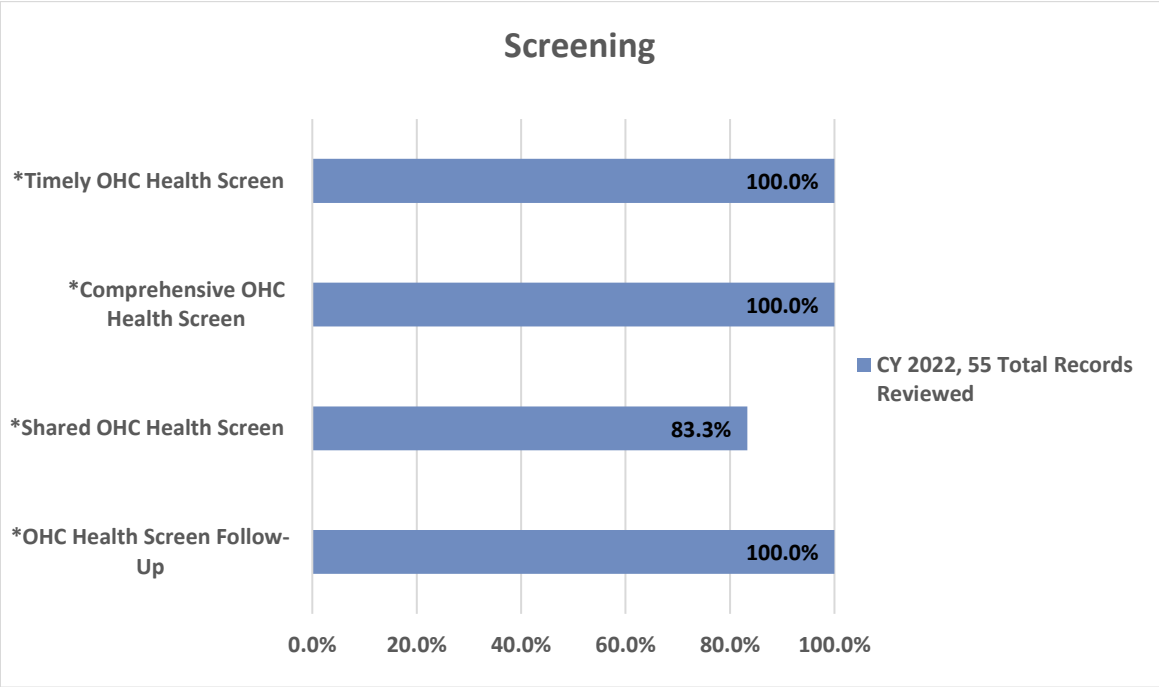
Indicator *Timely OHC Health Screen* ensures the OHC Health Screen was completed timely based on contract requirements. The organization demonstrated OHC Health Screens are completed within two business days of entry into out-of-home care. Eight out of 55 records reviewed were exempt from OHC Health Screens. Twenty-four records reviewed required OHC Health Screens. Of the 24 applicable records, 19 records demonstrated OHC Health Screens were completed beyond the required timeframe but were considered met due to COVID-19 flexibilities.

Indicator *Comprehensive OHC Health Screen* ensures the OHC Health Screen is comprehensive based on the DHS-PIHP contract requirements. The organization demonstrated the OHC Health Screen included all required elements evidencing comprehensiveness.

Indicator *Shared OHC Health Screen* ensures the OHC Health Screen was shared with all required health and child welfare providers. The most common reason this indicator was not met was OHC Health Screens were not shared with the member's Primary Care Provider (PCP).

Indicator *OHC Health Screen Follow-Up* ensures follow-up occurs for all immediate or emergent needs uncovered during the OHC Health Screen. The organization demonstrated immediate or emergent needs identified through the OHC Health Screen received timely follow-up.

The following graph demonstrates the PIHP's rate at which the standards were met for each indicator in FY 22-23. Following the FY 21-22 care management review, the review was revised at the request of DHS. Ratings from the previous year are not comparable.



*Note: The review indicators *Timely OHC Health Screen, Comprehensive OHC Health Screen, and Shared OHC Health Screen* applied to 24 of 55 records in FY 22-23. The review indicator *OHC Health Screen Follow-Up* applied to two of 55 records in FY 22-23.

Observations and Analysis: Assessment

The initial health assessment must be completed within 30 calendar days of enrollment, and include a comprehensive HealthCheck exam as well as mental/behavioral health and/or developmental assessments, as indicated. The initial health assessment must be comprehensive and all identified needs uncovered during the assessment should receive appropriate follow-up.

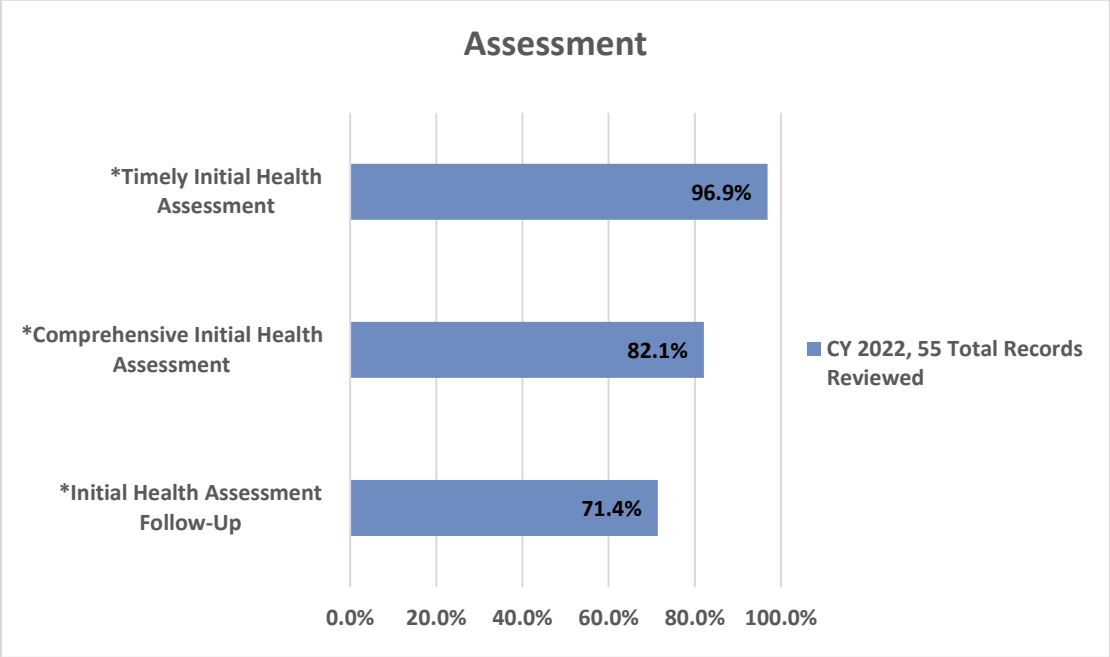
Indicator *Timely Initial Health Assessment* ensures the initial health assessment was completed timely. The organization demonstrated the initial health assessments were completed within 30

days of enrollment. Twenty-four records reviewed required initial health assessments. Of the 24 applicable records, seven records demonstrated initial health assessments were completed beyond the required timeframe but were scored as met due to COVID-19 flexibilities.

Indicator *Comprehensive Initial Health Assessment* ensures the initial health assessment was comprehensive. The most common reasons initial health assessments were not comprehensive was the assessment did not document the review of the member's behavioral and oral health.

Indicator *Initial Health Assessment Follow-Up* ensures identified needs uncovered during the initial health assessment received follow-up. Records found unmet for this indicator were due to a lack of documented follow-up for various physical health needs uncovered during the initial health assessment.

The following graph demonstrates the PIHP's rate at which the standards were met in FY 22-23. Following the FY 21-22 care management review, the review was revised at the request of DHS. Ratings from the previous year are not comparable.



*Note: The review indicator *Timely Initial Health Assessment* applied to 32 of 55 records in FY 22-23. The review indicator *Comprehensive Initial Health Assessment* applied to 28 of 55 records in FY 22-23. The review indicator *Initial Health Assessment Follow-Up* applied to seven of 55 records in FY 22-23.

Observations and Analysis: Care Planning

The initial care plan must be completed within the first 60 calendar days of enrollment. Ongoing care plans must be reviewed and updated at least once every six months or when indicated. The care plan review must include the child, Primary Care Provider (PCP), OHC provider(s),

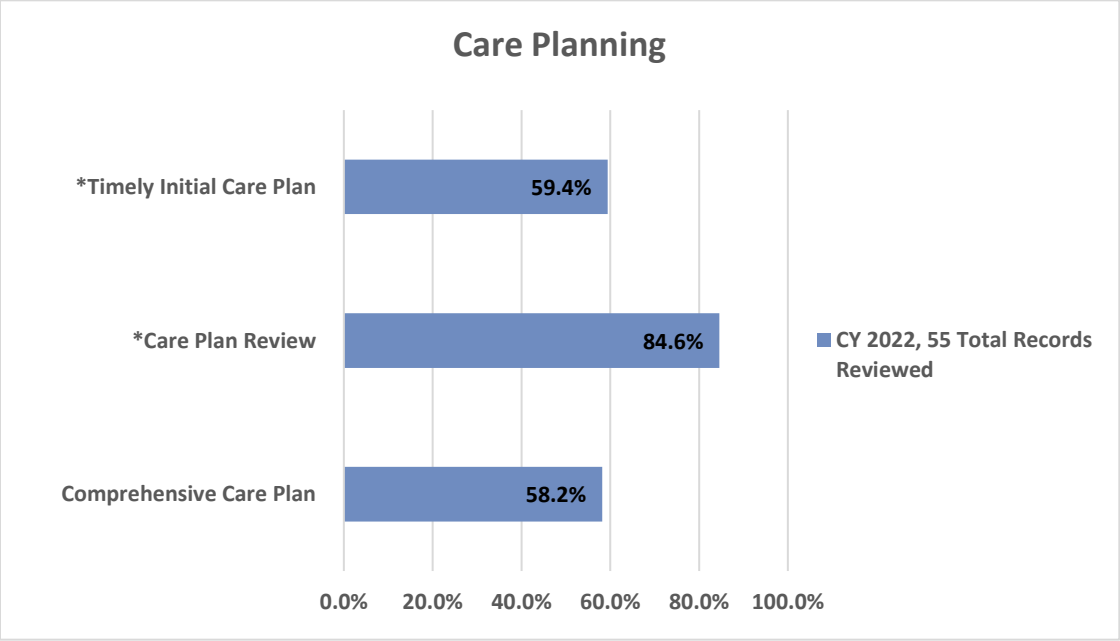
parent/legal guardian, and child welfare case worker. A comprehensive care plan is evident when all required elements are documented.

Indicator *Timely Initial Care Plan* ensures the initial care plan was developed timely. The care plan should include input from all required persons to be considered developed. The most common reason care plans were not fully developed within 60 days of enrollment was input from the parent/legal guardian or the PCP was not evidenced.

Indicator *Care Plan Review* ensures the care plan was reviewed and updated as required by the DHS-PIHP contract. The care plan should include input from all required persons to be considered reviewed. The most common reason care plans were not fully reviewed at least once every six months or when indicated was input from the parent/legal guardian or the out-of-home provider was not evidenced.

Indicator *Comprehensive Care Plan* ensures the care plan was comprehensive. The most common reasons care plans were not comprehensive was the care plan did not include evidence the care plan was communicated to the parent/legal guardian for input, tracking and timely follow-up on referrals, individualized member crisis plans, and transition plans between inpatient and outpatient settings.

The following graph demonstrates the PIHP's rate at which the standards were met in FY 22-23. Following the FY 21-22 care management review, the review was revised at the request of DHS. Ratings from the previous year are not comparable.



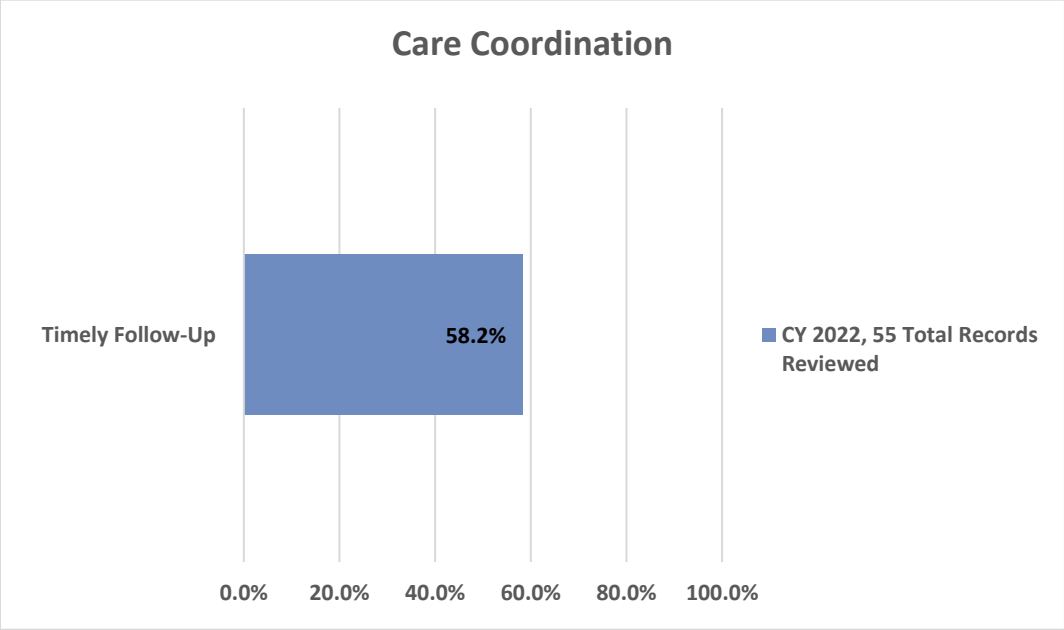
*Note: The review indicator *Timely Initial Care Plan* applied to 32 of 55 records in FY 22-23. The review indicator *Care Plan Review* applied to 13 of 55 records in FY 22-23.

Observations and Analysis: Care Coordination

The record 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 to address each need, and identify a team member responsible for each need. The services and supports must be coordinated in a reasonable amount of time.

Indicator *Timely Follow-Up* ensures the member's needs and services receive ongoing monitoring and follow-up. Records found unmet for this indicator were due to a lack of documented follow-up for the member's identified physical, mental, and oral health care needs.

The following graph demonstrates the PIHP's rate at which the standards were met in FY 22-23.



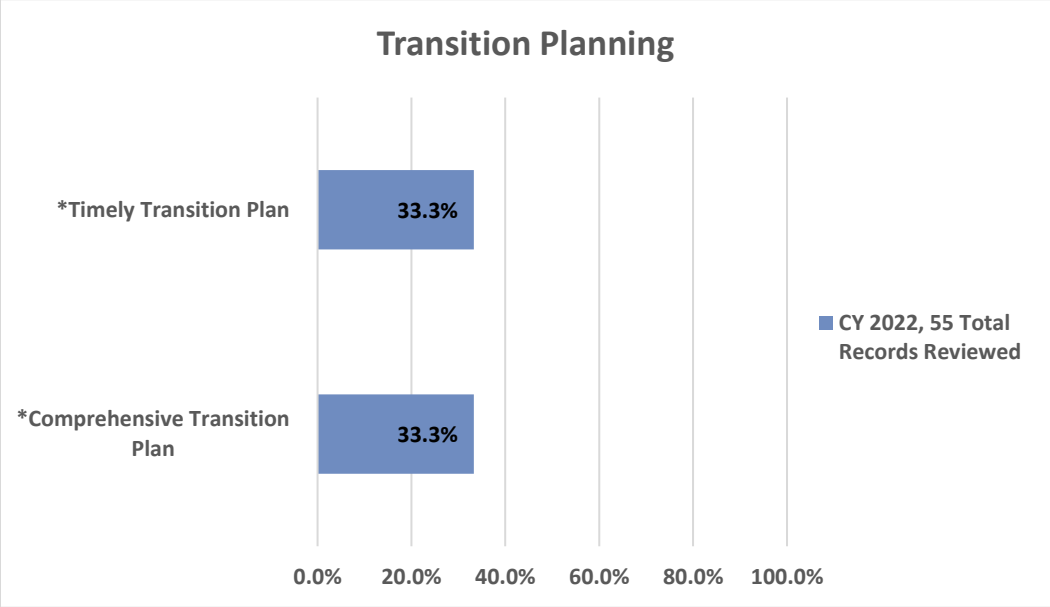
Observations and Analysis: Transition Planning

The record should document that transitional care planning occurred prior to a child leaving the FCMH. This requirement was applicable to three of 55 records reviewed. The record must contain documentation of a transitional health care plan that meets DHS-PIHP contract requirements. A transition plan must be created prior to program disenrollment, and must be comprehensive.

Indicator *Timely Transition Plan* ensures the transition plan was created prior to disenrollment. Most transition plans were not created prior to program disenrollment.

Indicator *Comprehensive Transition Plan* ensures the transition plan was comprehensive. The most common reasons transition plans were not comprehensive was the transition plan did not identify the member's presumed source of ongoing insurance coverage and the member's PCP.

The following graph demonstrates the PIHP's rate at which the standards were met in FY 22-23. Following the FY 21-22 care management review, the review was revised at the request of DHS. Ratings from the previous year are not comparable.



*Note: The review indicators *Timely Transition Plan* and *Comprehensive Transition Plan* applied to three of 55 records in FY 22-23.

CONCLUSIONS

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

APPENDIX A: INFORMATION SYSTEMS CAPABILITIES ASSESSMENT

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

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

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 calendar year to align with the Centers for Medicare & Medicaid Services External Quality Review Protocols, which define the review activities for Medicaid Managed Care Programs. As a result of the revisions, the year-to-year aggregated results are no longer comparable.

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.

Overall Results

During CY 2022, MetaStar conducted ISCAs for three MCOs selected by DHS. The organizations were Group Health Cooperative of Eau Claire (GHC-EC), Independent Care Health Plan (*i*Care), and My Choice Wisconsin (MCW).

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.

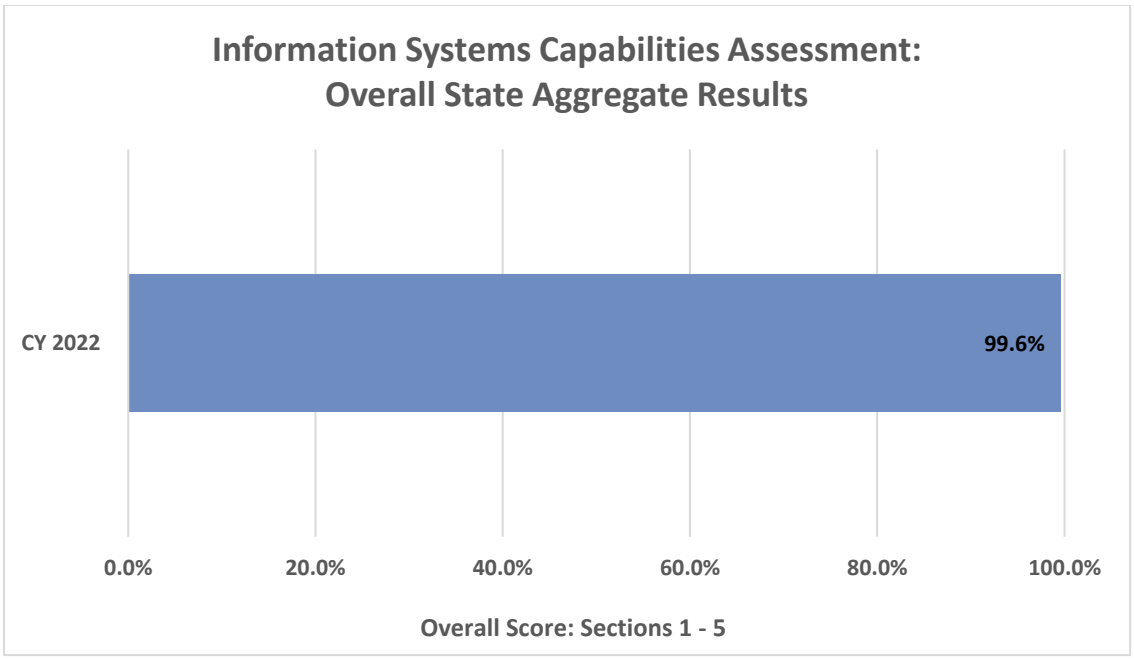
Scoring Legend	
Percentage Met	**Rating**
90.0% - 100.0%	Excellent
80.0% - 89.9%	Very Good
70.0% - 79.9%	Good
60.0% - 69.9%	Fair
< 60.0%	Poor

Aggregately, the MCOs had an overall score of 99.6 percent, and a rating of Excellent. The table below displays the aggregate number of scoring elements for each section, the percentage of scoring elements met, and the rating for each section.

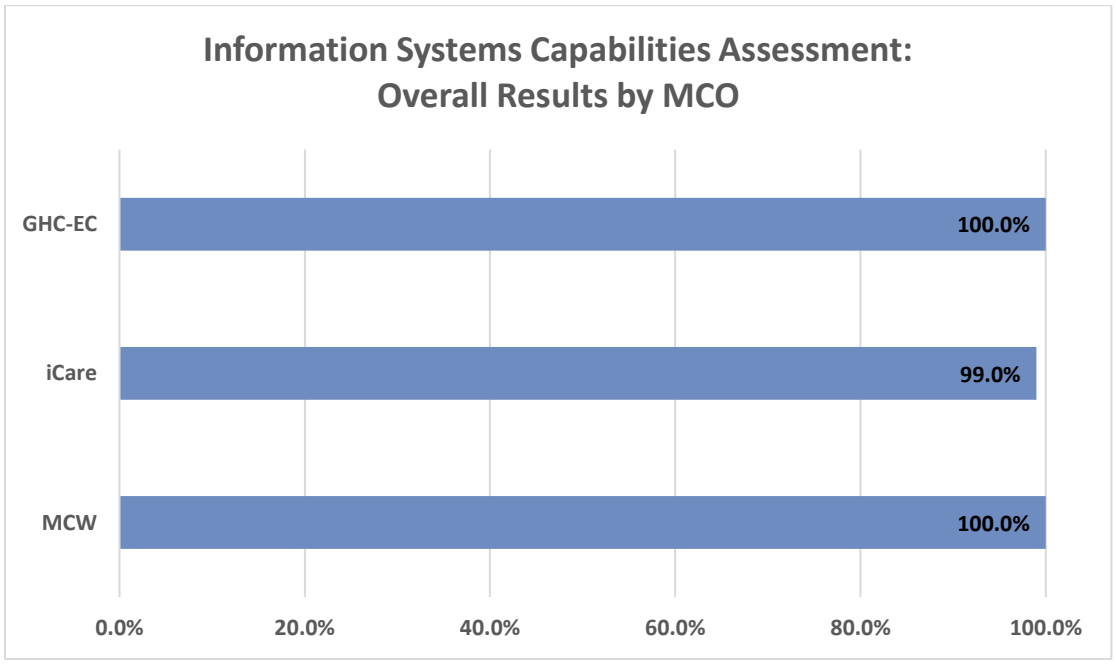
Information Systems Capabilities Assessment CY 2022			
Focus Area	**Scoring Elements**	**Percentage Met**	**Rating**
Section 1: Background Information*	N/A	N/A	N/A
Section 2: Information Systems	45/45	100.0%	Excellent
Section 3: Staffing	6/6	100.0%	Excellent
Section 4: Security	78/78	100.0%	Excellent
Section 5: Data Acquisition Capabilities	138/139	99.3%	Excellent
Overall	**267/268**	**99.6%**	**Excellent**

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

The graph on the next page illustrates the State's overall compliance with these standards. As indicated above, the year-to-year results are no longer comparable due to the revisions to the ISCA; therefore, comparisons to prior ISCAs are not included.



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



Results for each ISCA Focus Area

Observation and Analysis: Section 1. Background Information

The MCOs detailed the type of managed care program operated by each MCO, the year the organizations were incorporated, average enrollment by program, and when the previous ISCAs were conducted. This section is for informational purposes only and is not included in the scoring calculations. The following table includes the background information for each MCO.

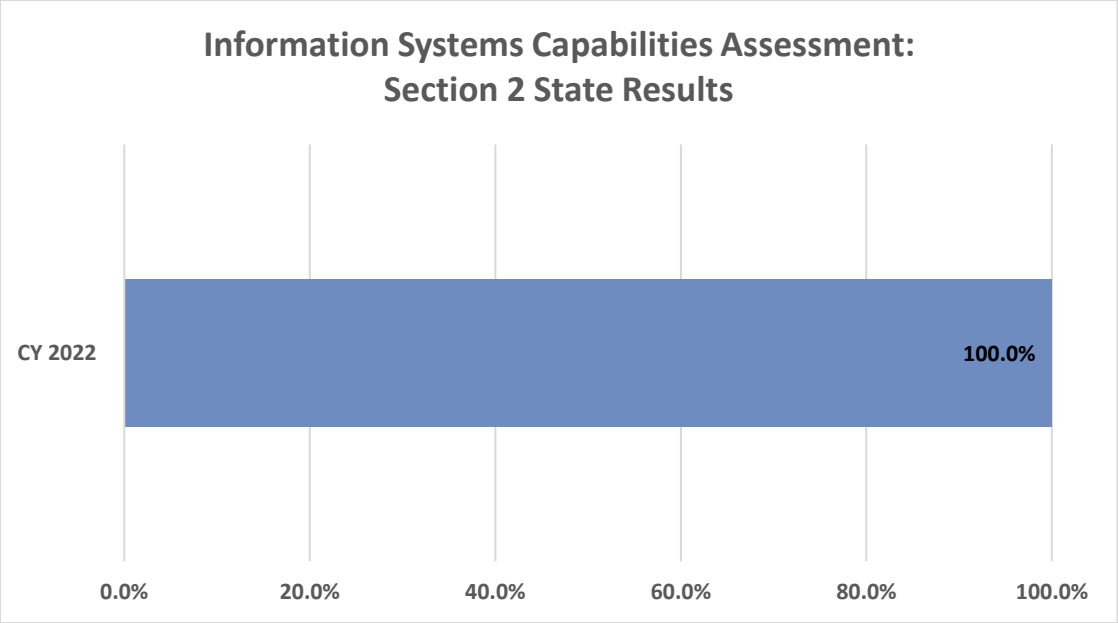
MCO Background Information			
MCO:	GHC-EC	*i*Care	MCW
Date of Incorporation:	1972	2003	2020
Prior ISCA:	October 2019	November 2019	N/A*
Average SSI Enrollment:	3,457	10,913	3,361
Average BC+ Enrollment:	56,264	32,397	22,964

*Note: MCW was newly formed in 2020; this is the first evaluation conducted for the new organization.

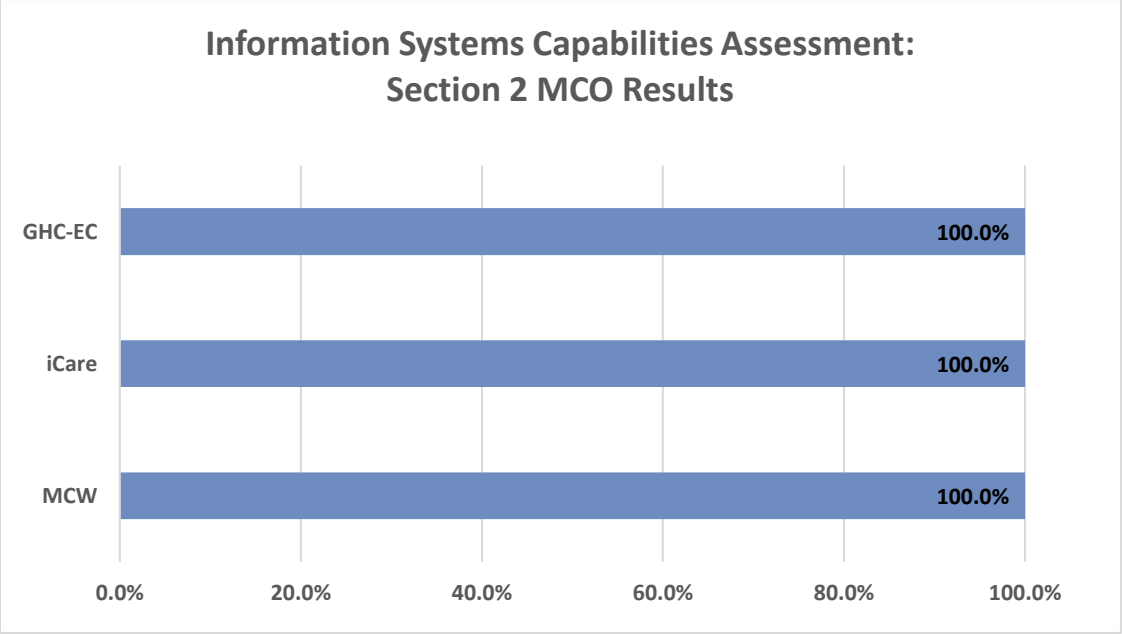
Observation and Analysis: Section 2. Information Systems - Data Processing & Personnel

Each MCO 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. Section 2 contains 15 possible scoring elements for each MCO reviewed. The MCOs satisfied requirements for 45 out of 45 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The graph on the next page illustrates the State's overall compliance with these requirements. As indicated above, the year-to-year results are no longer comparable due to the revisions to the ISCA; therefore, comparisons to prior ISCAs are not included.



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



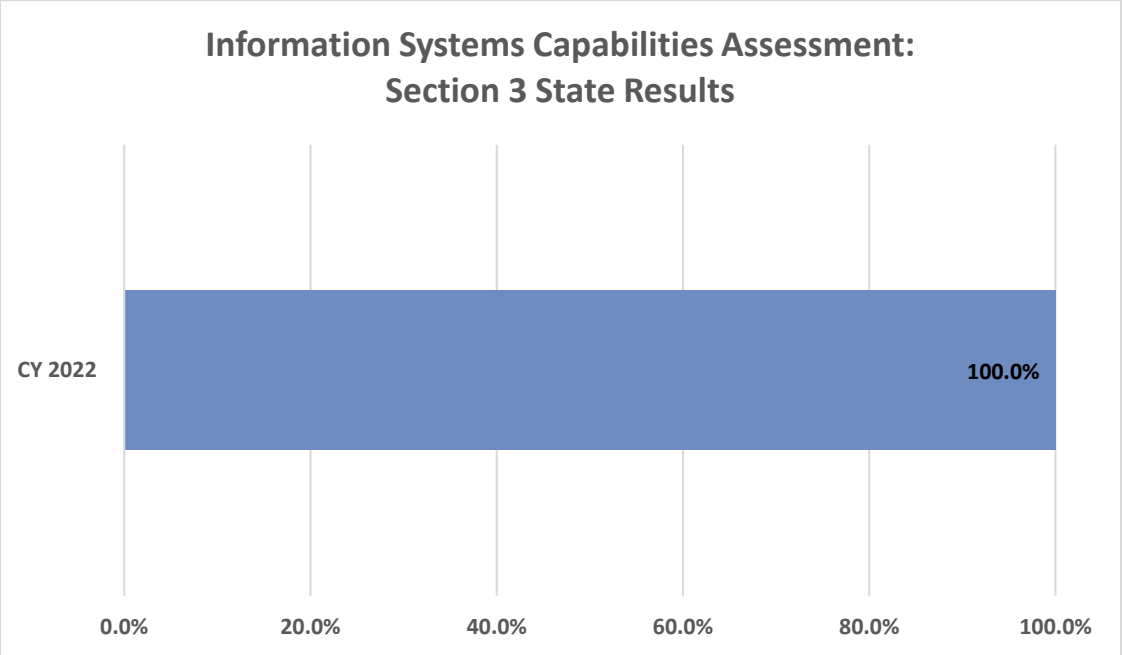
The responses submitted and interview sessions with MCO staff satisfied requirements of this focus area. Two of the three MCOs contract with third-party vendors who gather and process claims and encounter data to DHS, and the other MCO continues to process all claims and create encounter data using in-house systems and programming staff. All three organizations use version control software for change management and deployment to the production environment,

and follow a documented production change control process prior to modifying any code. When changes to the claims, encounter, or enrollment tracking systems are required, each MCO undertakes a strategic and priority driven approach to implement and test the change prior to production.

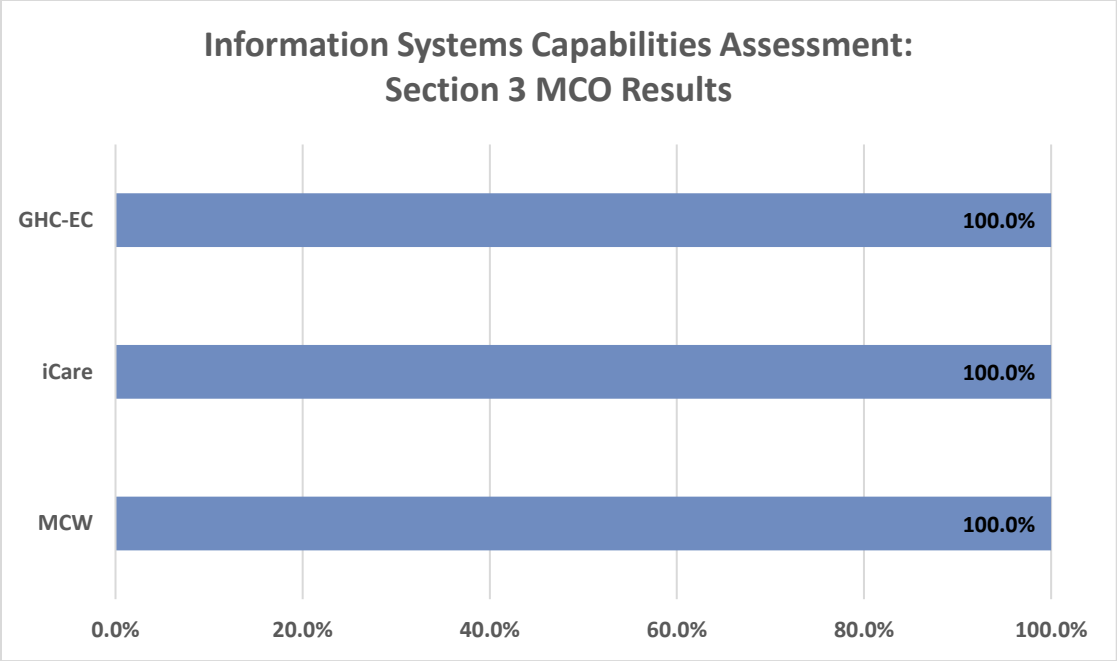
Observation and Analysis: Section 3. Staffing

Each MCO's 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. Section 3 contains two possible scoring elements for each MCO reviewed. The MCOs satisfied requirements for six out of six scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The graph below illustrates the State's overall compliance with these requirements. As indicated above, the year-to-year results are no longer comparable due to the revisions to the ISCA; therefore, comparisons to prior ISCAs are not included.



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

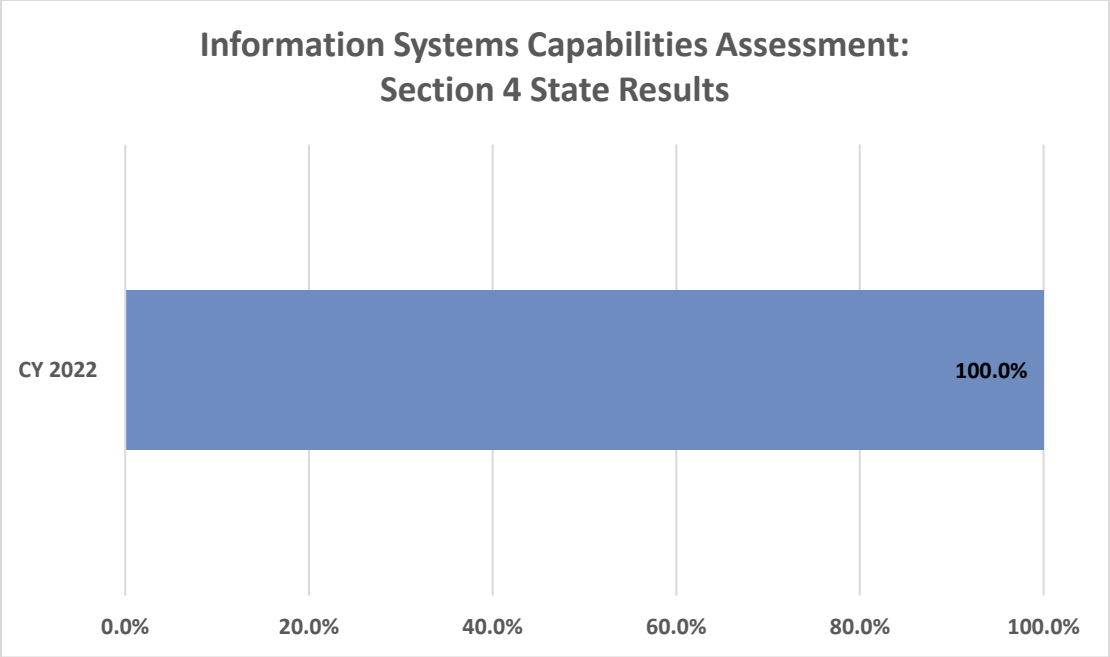


The responses submitted and interview sessions with MCO staff satisfied requirements of this focus area. Each organization has designed a training program for new hires based on the needs and skill sets of the individual, which involves virtual training, mentoring, and shadowing current staff. Validation or auditing of work conducted by new staff occurs frequently upon hire and tapers over time. All MCOs reported that refresher trainings occur at a minimum annually based on policy updates, standard audits of work, error trends, and productivity reports.

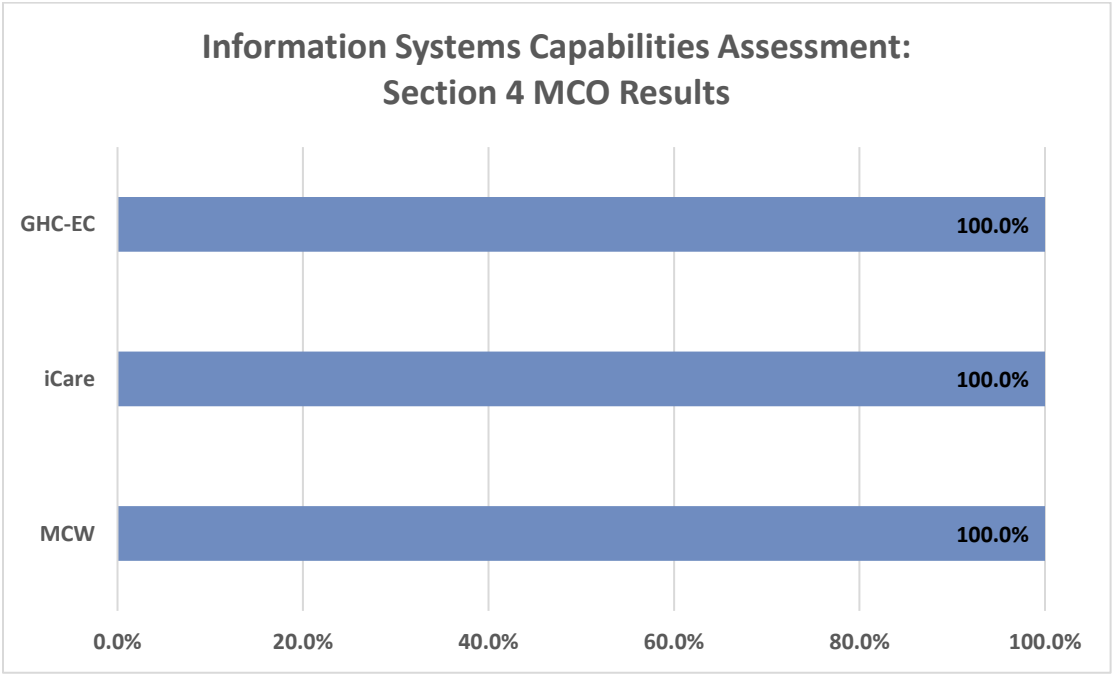
Observation and Analysis: Section 4. Security

Each MCO 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. MCOs should have data backing and disaster recovery procedures, including testing. Section 4 contains 26 possible scoring elements for each MCO. The MCOs satisfied requirements for 78 out of 78 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The graph on the next page illustrates the State's overall compliance with these requirements. As indicated above, the year-to-year results are no longer comparable due to the revisions to the ISCA; therefore, comparisons to prior ISCAs are not included.



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



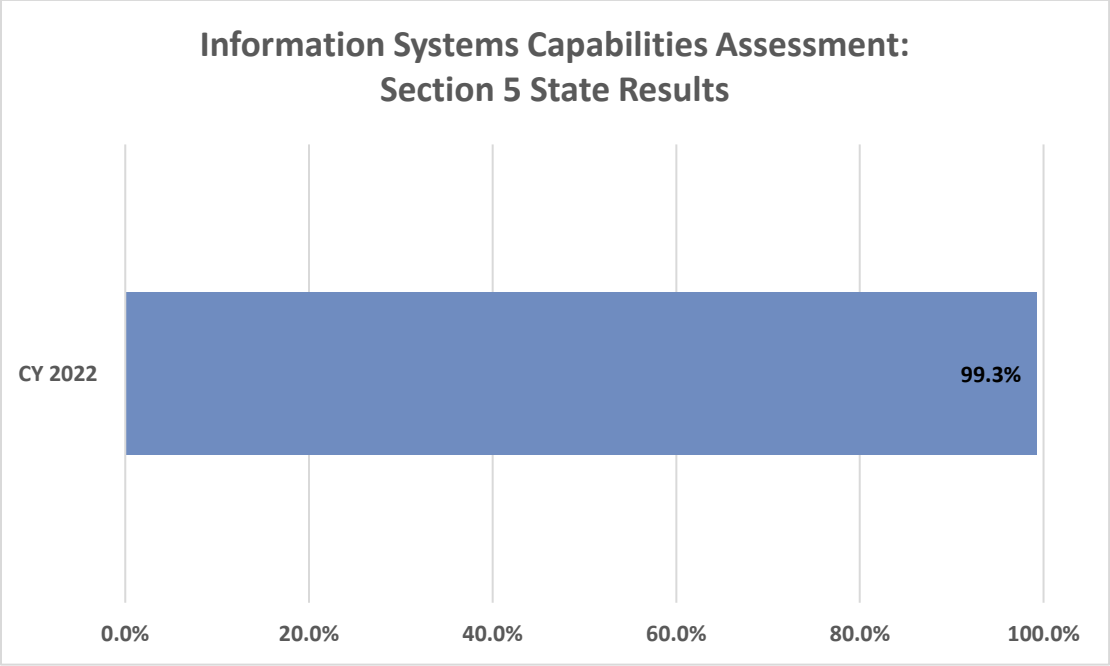
The responses submitted and interview sessions with MCO staff satisfied requirements of this focus area. Each MCO has a disaster recovery system to enable each organization to keep business functions running in the event of a disaster or failover. Physical security of information

was adapted by each MCO due to the Public Health Emergency (PHE) and *Wisconsin's Safer at Home* order during the Coronavirus-2019 (COVID-19) pandemic. Productivity and accuracy of work is monitored, and each organization's physical security practices and policies have remained in place regardless of whether staff are working remotely or in the office.

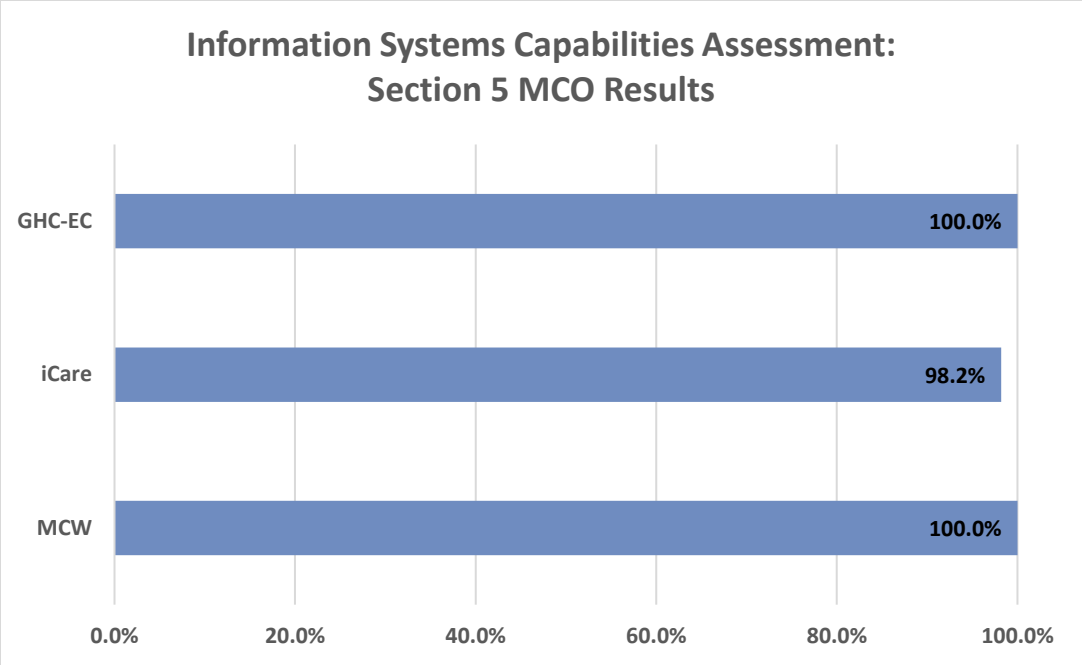
Observation and Analysis: Section 5. Data Acquisition Capabilities

MCOs 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. Section 5 contains 48 possible scoring elements for each MCO. The MCOs satisfied requirements for 138 out of 139 scoring elements, for a score of 99.3 percent, and a rating of Excellent.

The graph below illustrates each MCO's overall compliance with these requirements. As indicated above, the year-to-year results are no longer comparable due to the revisions to the ISCA; therefore, comparisons to prior ISCAs are not included.



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



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 MCOs.

The responses submitted and interview sessions with MCO staff satisfied requirements of this focus area. For the MCOs that utilize third party administrators (TPAs) for claims processing, service level agreements were in place between the TPAs and the MCOs which specify expectations regarding accuracy and timeliness of claims processing. Pended claims reports are reviewed by each respective organization at least on a weekly basis, and efforts are underway to improve the electronic submission rate of claims from providers and the auto-adjudication rate for claims processing.

5B. Enrollment System

This section focuses on the processing and management of enrollment data.

The responses submitted and interview sessions met requirements of this focus area. Each MCO has the systems and processes in place to accurately collect, manage, and retain the eligibility, enrollment, and disenrollment data. Unique member identification numbers remain linked to members throughout their enrollment in any program provided by each organization, and systems are in place to flag and eliminate duplicate member identification numbers.

5C. Ancillary Systems

This section focuses on use and oversight of third-party data.

The responses submitted and interview sessions with MCO staff satisfied most requirements of this focus area. Two MCOs utilize third-party vendors to process vision and dental claims, and produce encounter data for reporting to DHS. Service level agreements are utilized with these vendors to monitor performance and quality of reporting prior to submitting the encounter data files to DHS.

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.

The responses submitted and interview sessions with MCO staff satisfied requirements of this focus area. Each MCO receives supplemental data from entities that support quality reporting for HEDIS® measures. The data files are loaded into the organization's data repositories separate from encounter files, and validation procedures are in place to ensure codes or data included in the file extracts are accurate.

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

This section focuses on how each MCO integrates Medicaid claims, encounter, membership, provider, third-party, and other data to calculate performance rates. The MCOs report HEDIS® measures and other Medicaid performance measures to DHS for the BC+ and SSI programs. These measures are validated through audits separate from the ISCA review. As a result, this section is not applicable to the MCOs.

CONCLUSIONS

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

Care Management Review (CMR) – 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.

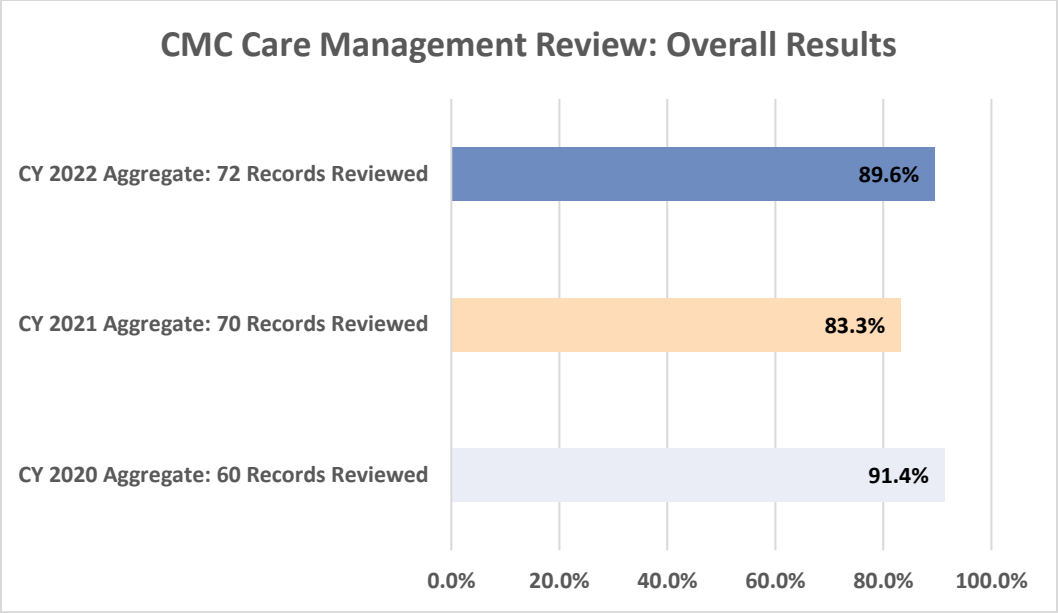
The CMC CMR is an optional activity. MetaStar reviewed 70 records of CMC participants enrolled through three hospitals. The review focused on five categories:

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

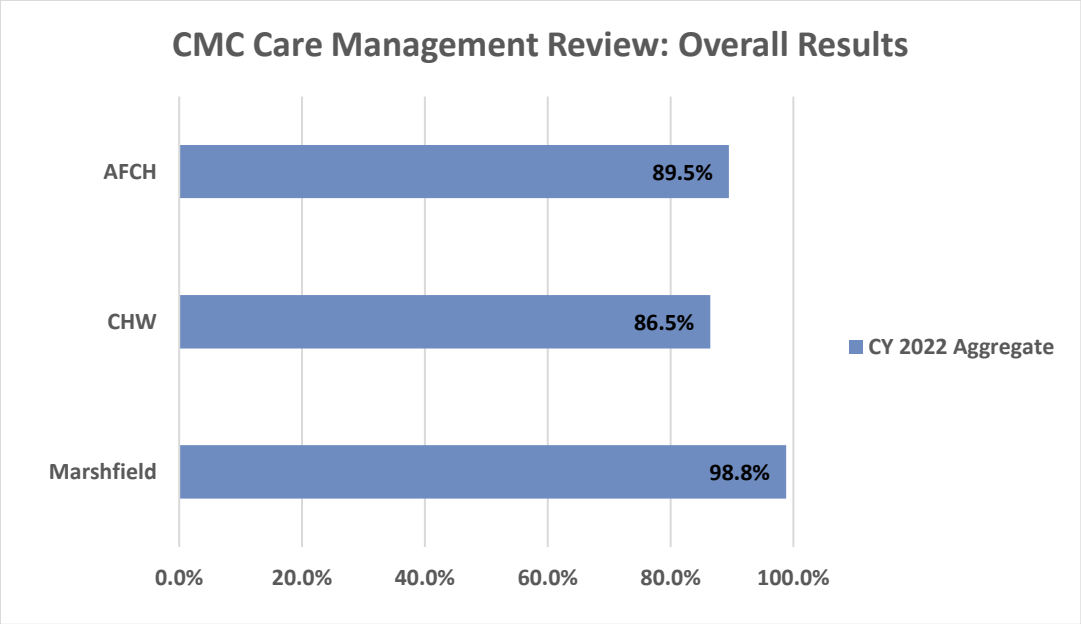
More information about the review methodology can be found in Appendix 2.

Overall Results

The bar graph on the next page represents the overall percent of CMR standards met by the hospitals operating the CMC program, which is the State's overall compliance rate. The results improved from the prior review and analysis indicated the year-to-year difference in the rates is likely attributable to actions of the hospitals to improve practices, and unlikely to be the result of normal variation and chance.



The graph below illustrates each hospitals' overall compliance with these standards in CY 2022.



Results for each CMR Focus Area

Each section below provides a brief explanation of a key category of CMR, followed by a bar graph which displays CY 2022 results for each indicator that comprises the CMR category. CY 2021 and CY 2020 aggregate results are provided for comparison. An additional bar graph is included to compare the results of each hospital reviewed in CY 2022.

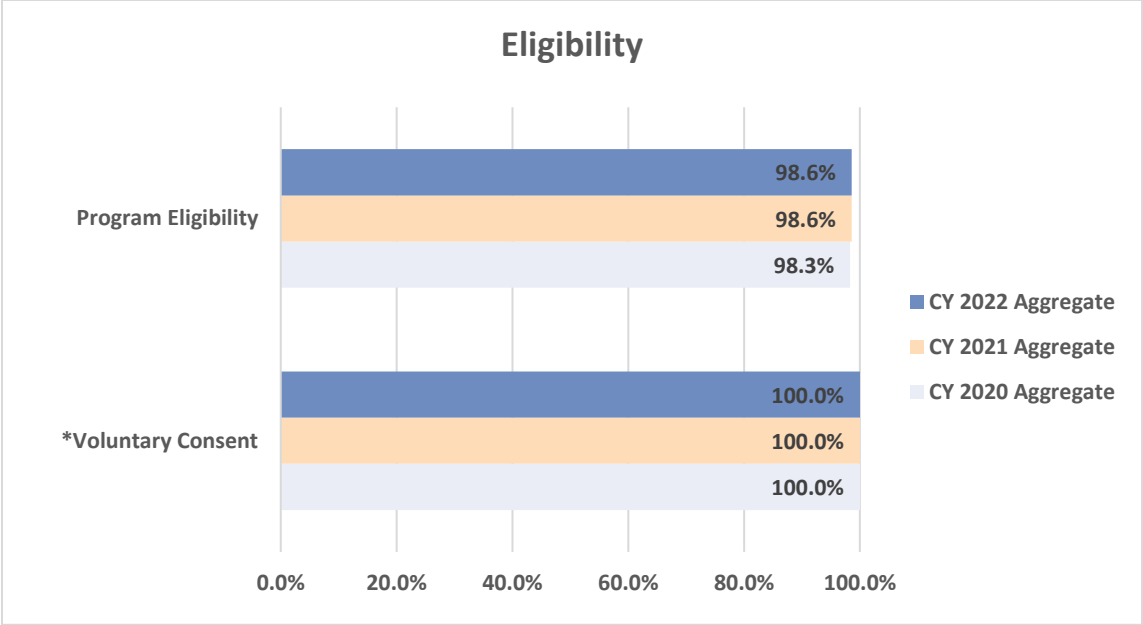
ELIGIBILITY

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

The indicator *Program Eligibility* ensures all members who receive services are eligible for the program. Analysis indicated the year-to-year difference in the eligibility requirements rates is likely due to normal variation or chance. This indicator continues to be a strength for the CMC program, scoring over 90.0 percent in the prior two reviews. The organizations had processes in place to ensure all members met eligibility requirements.

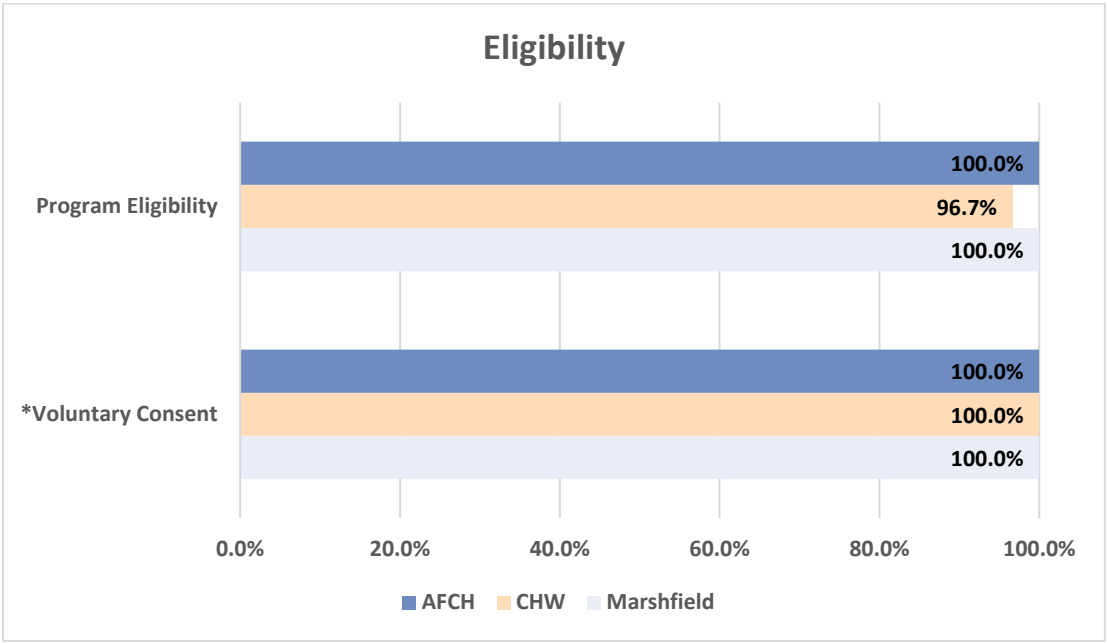
The indicator *Voluntary Consent* ensures the member's legal guardian voluntarily consents to participate in the program. Analysis indicated the year-to-year difference in the voluntary consent rates is likely due to normal variation or chance. This indicator continues to be a strength for the CMC program, scoring 100.0 percent in the prior two reviews. The organizations had strong methods in place to ensure the voluntary consent was obtained when applicable.

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



*Note: The review indicator *Voluntary Consent* applied to 7 of 70 records in CY 2022, 8 of 70 records in CY 2021, and 5 of 60 records in CY 2020

The graph below illustrates each hospitals' overall compliance with the eligibility standards.



*Note: The review indicator *Voluntary Consent* applied to 3 of 30 records for AFCH, 3 of 30 records for CHW, and 1 of 10 for MCH.

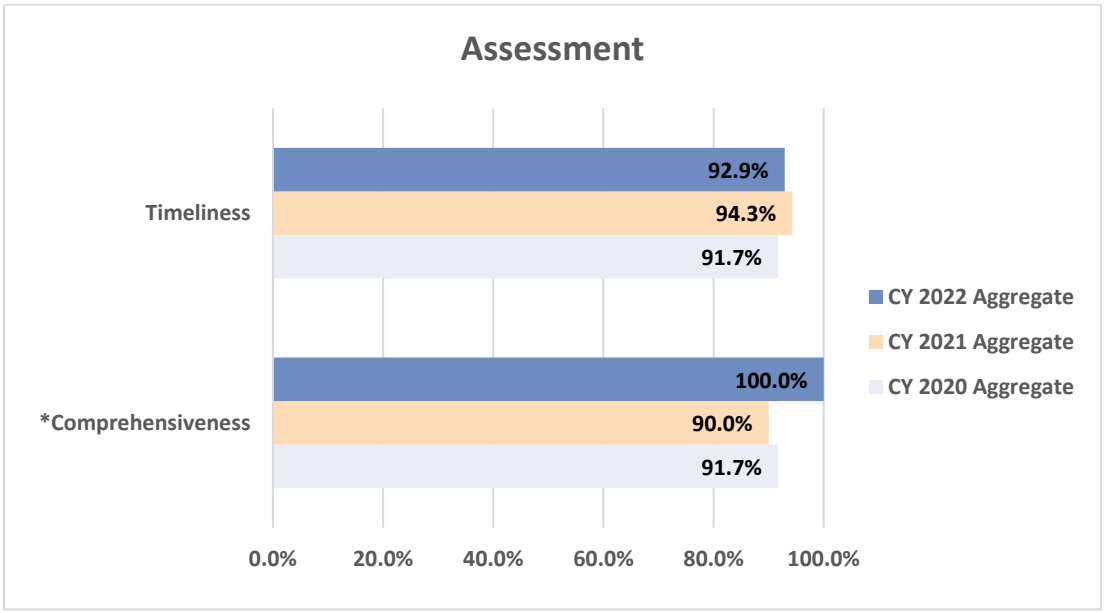
ASSESSMENT

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 (for example, family members and educational providers), includes the member's history, and identifies the member's needs and strengths.

The indicator *Timeliness* ensures initial and periodic assessments are completed within the required timeframes outlined in the DHS-MCO contract requirements. Analysis indicated the year-to-year difference in the timely assessment rates is likely due to normal variation or chance. This indicator continues to be a strength for the CMC program, scoring over 90.0 percent in the prior two reviews. The organizations ensured assessments were completed timely.

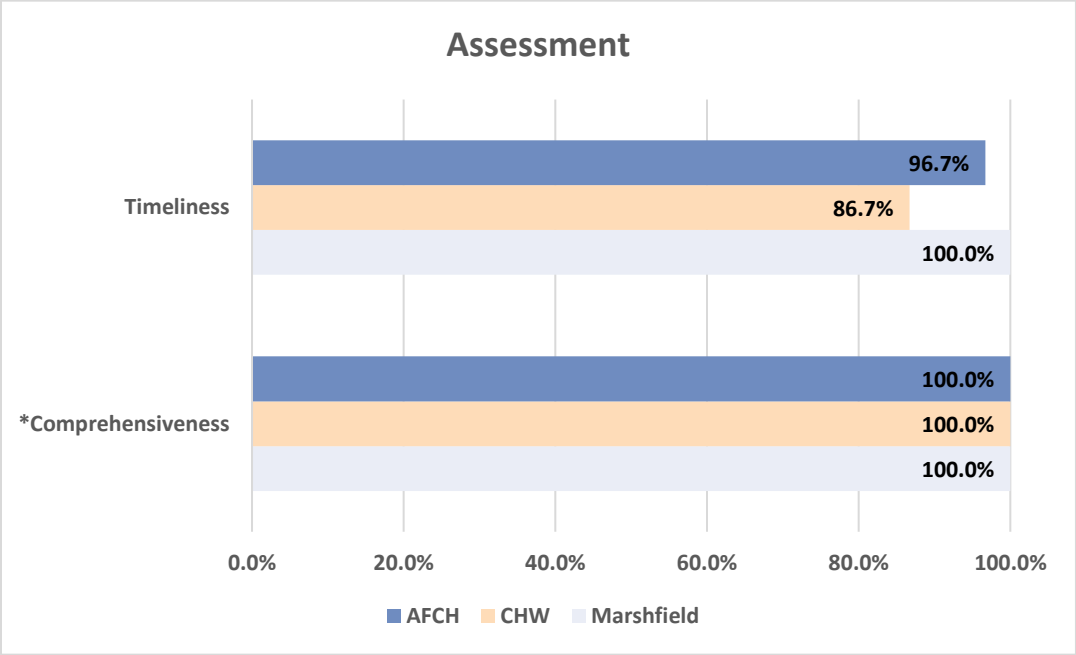
The indicator *Comprehensiveness* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. Analysis indicated the year-to-year difference in the comprehensiveness rates is likely attributable to actions of the hospitals and is unlikely to be the result of normal variation or chance. This indicator continues to be a strength for the CMC program, scoring over 90.0 percent in the prior two reviews. The organizations developed comprehensive assessments.

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



*Note: The review indicator *Comprehensiveness* applied to 67 of 70 records in CY 2022, 70 of 70 records in CY 2021, and 60 of 60 records in CY 2020.

The graph below illustrates each hospital's overall compliance with the assessment standards.



*Note: The review indicator *Comprehensive Assessment* applied to 30 of 30 records for AFCH, 27 of 30 records for CHW, and 10 of 10 for MCH.

Care Plans

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

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

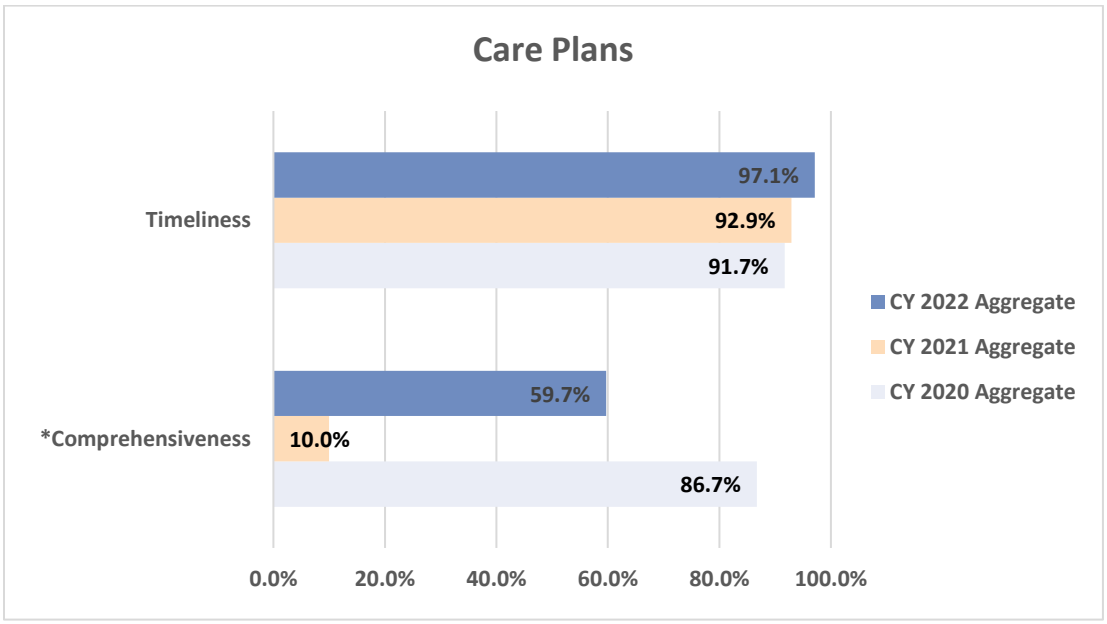
The initial care plan must also contain evidence that development occurred during a face-to-face meeting between the member, family, and physician or advanced practitioner. Care plans must be reviewed at least every six months or as a member's needs change.

The indicator *Timeliness* ensures initial and periodic care plans are completed within the required timeframes outlined in the DHS-MCO contract requirements. Analysis indicated the year-to-year difference in the timeliness rates is likely due to normal variation or chance. This indicator continues to be a strength for the CMC program, scoring over 90.0 percent in the prior two reviews. The organizations had processes in place to ensure care plans were completed timely.

The indicator *Comprehensiveness* ensures member care plans include all assessed needs. Overall results for this indicator increased from the prior review. The review conducted in CY 2021 included the review of SMART goals in the comprehensive care plan. In CY 2022, the

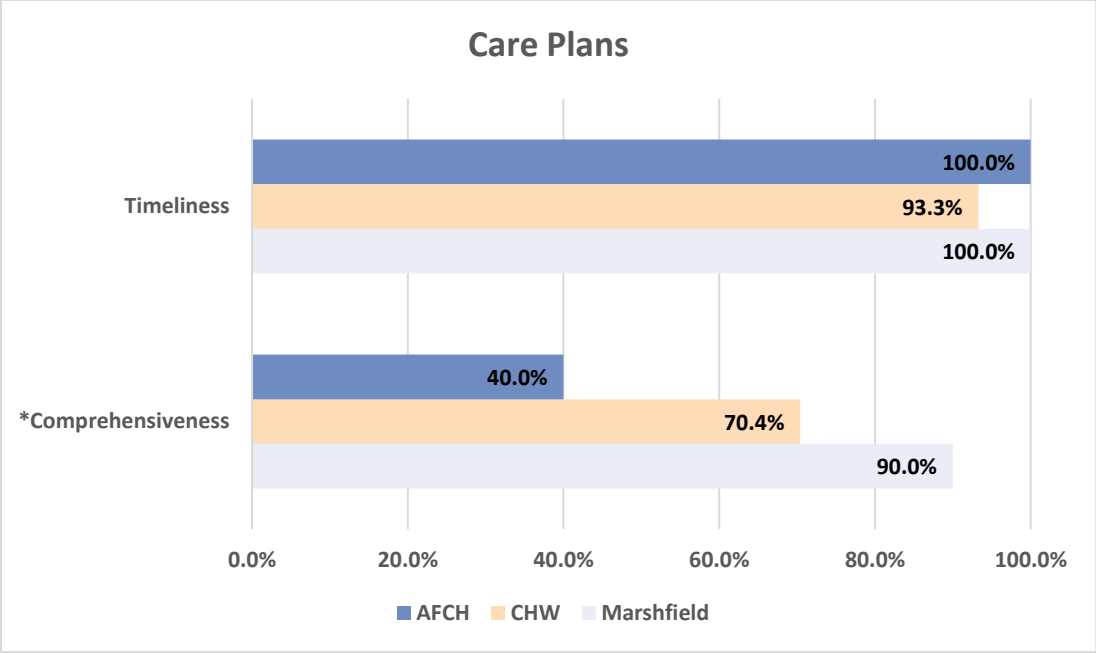
requirement to include SMART goals was eliminated based on DHS guidance and redrafted to include member-centric goals that include program requirements; therefore, year-to-year change in rates is not comparable for this indicator.

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



*Note: The review indicator *Comprehensiveness* applied to 67 of 70 records in CY 2022, 70 of 70 records in CY 2021, and 60 of 60 records in CY 2020.

The graph on the next page illustrates each hospital's overall compliance with the care plan standards.



*Note: The review indicator *Comprehensiveness* applied to 30 of 30 records for AFCH, 27 of 30 records for CHW, and 10 of 10 for MCH.

Service Reduction or Termination

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

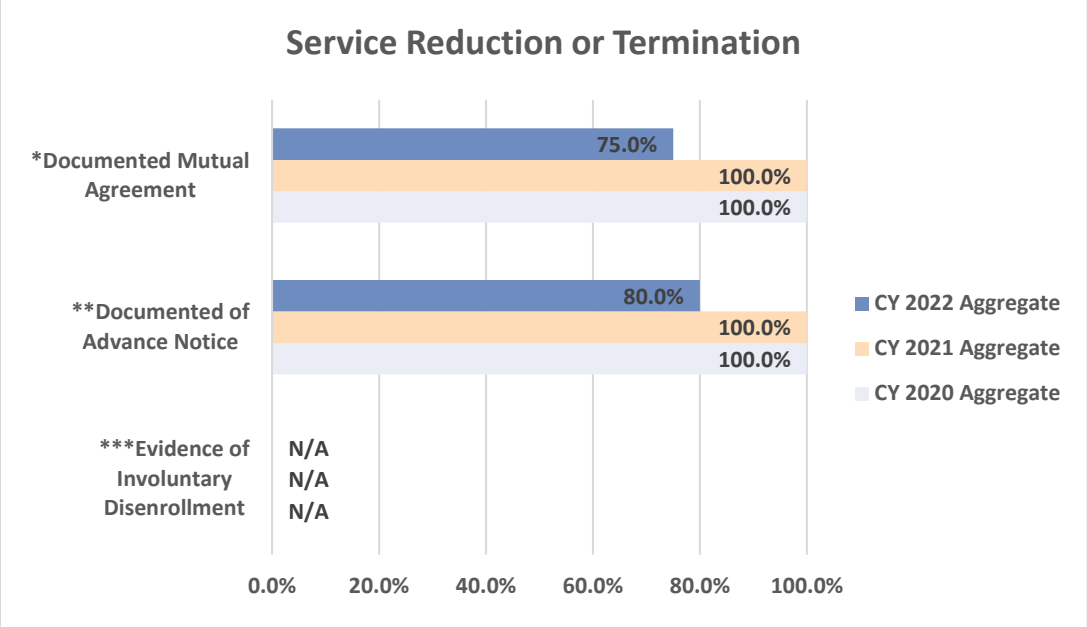
Indicator *Documented Mutual Agreement* ensures the member and legal guardian are in agreement with service reductions and/or the termination of services. Analysis indicated the year-to-year difference in the care plan change agreement rate is likely due to normal variation or chance. Overall results for this indicator decreased from the prior review. Records found unmet did not contain documented mutual agreement for changes in level of services.

Indicator *Documented of Advance Notice* ensures the member and legal guardian are given notice for change in level of services. Analysis indicated the year-to-year difference in the advanced notice of change rate is likely due to normal variation or chance. Overall results for this indicator decreased from the prior review. Records found unmet for this indicator did not contain advanced notice for changes in level of services.

Indicator *Evidence of Involuntary Disenrollment* ensures the organization only involuntarily disenrolls a member from the program when the member and/or family refuses to meet program

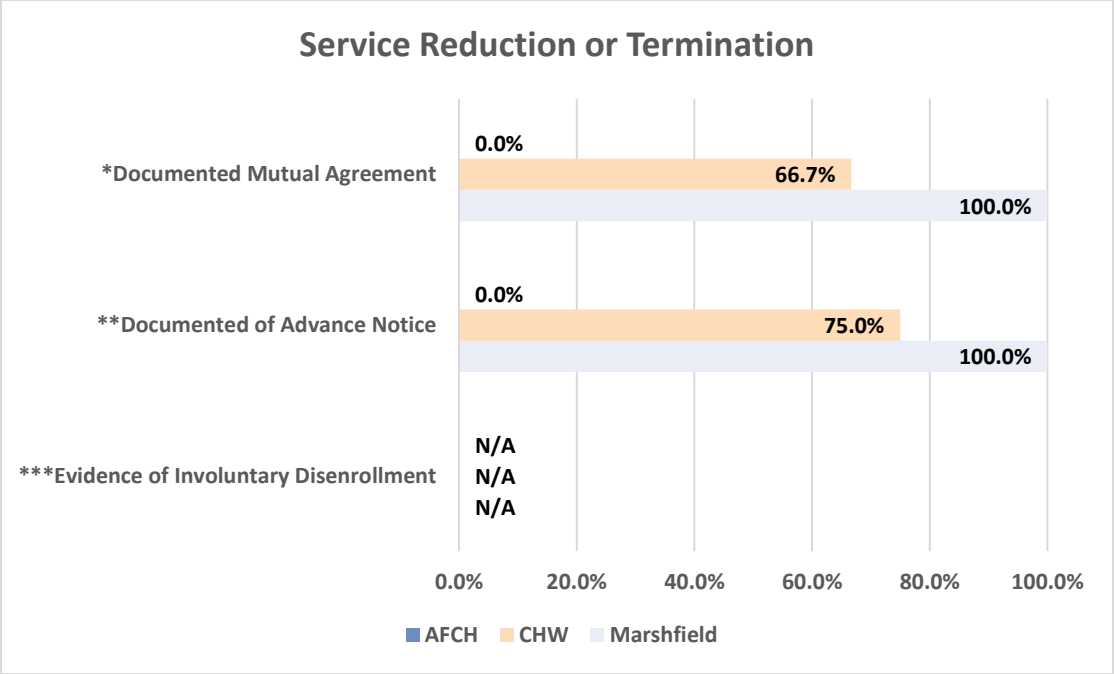
requirements and/or the organization loses contact with the member. No members were involuntarily disenrolled during the review period; therefore, this indicator was not applicable.

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



*Note: The review indicator *Documented Mutual Agreement* applied to 4 of 70 records in CY 2022, 5 of 70 records in CY 2021, and 1 of 60 records in CY 2020.
**Note: The review indicator *Documented of Advance Notice* applied to 5 of 70 records in CY 2022, 1 of 70 records in CY 2021, and 1 of 60 records in CY 2020.
*** Note: The review *indicator Evidence of Involuntary Disenrollment* did not apply to any records in CY 2022, 2021, and 2020.

The graph on the next page illustrates each hospitals' overall compliance with the service reduction or termination standards.



*Note: The review indicator *Documented Mutual Agreement* applied to 0 of 30 records for AFCH, 3 of 30 records for CHW, and 1 of 10 for MCH.
**Note: The review indicator *Advanced Notice of Change* applied to 0 of 30 records for AFCH, 4 of 30 records for CHW, and 1 of 10 for MCH.
*** Note: The review indicator *Evidence of Involuntary Disenrollment* did not apply to any records.

Monitoring and Service Coordination

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

Indicator *Ongoing Supportive Contacts* ensures that the member is able to access services and/or is receiving the services and care specified in the care plan. Analysis indicated the year-to-year difference in the ongoing supportive contacts rates are likely due to normal variation or chance. Overall results for this indicator decreased from the prior review. Records found unmet for this indicator did not meet minimum contact requirements, including one record that did not evidence rounds during an in-patient hospitalization.

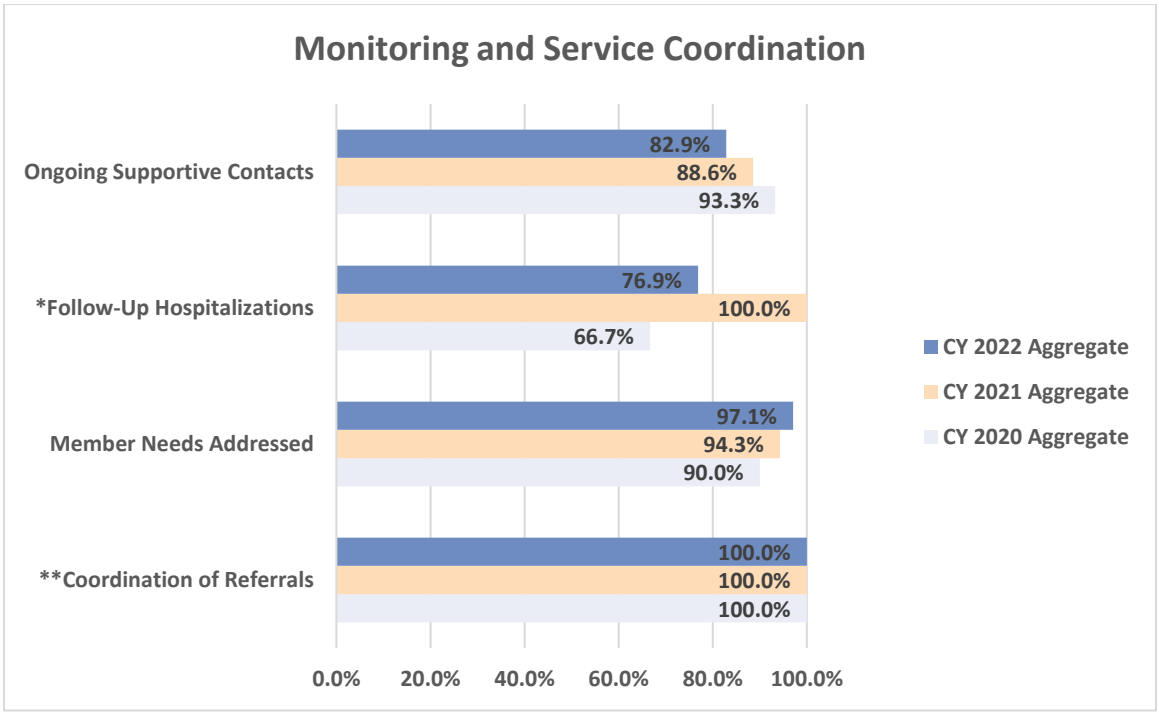
Indicator *Follow-Up Hospitalizations* ensures the MCO conducted follow-up with the member and legal guardian within three business days of hospital discharge. Analysis indicated the year-to-year difference in the hospitalization follow-up rates is likely attributable to actions of the hospitals and is unlikely to be the result of normal variation or chance. Overall results for this

indicator decreased from the prior review. Records found unmet for this indicator did not include hospitalization follow-up within the required timeframe.

Indicator *Member Needs Addressed* ensures the MCO conducted follow-up for identified member needs. Analysis indicated the year-to-year difference in the member needs follow-up rates are likely due to normal variation or chance. This indicator continues to be a strength for the CMC program, scoring over 90.0 percent in the prior two reviews. The organizations had processes in place to ensure member needs were addressed as required.

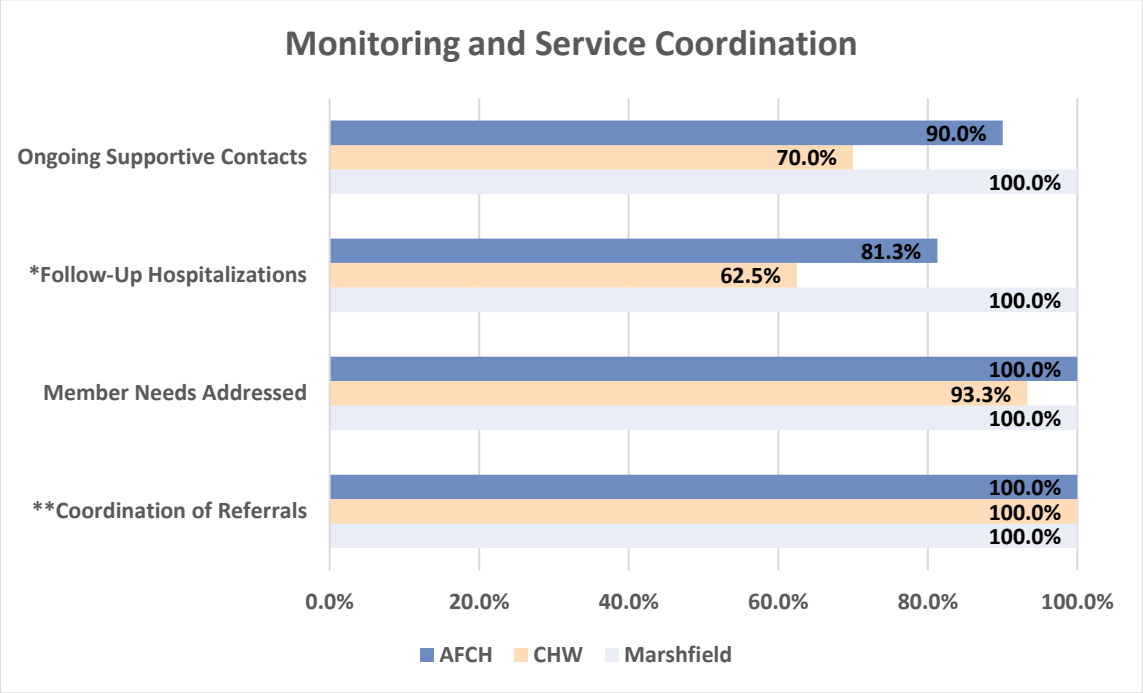
Indicator *Coordination of Referrals* ensures the MCO provides coordination and follow-up on all member referrals. Analysis indicated the year-to-year difference in the referral coordination rates are likely due to normal variation or chance. This indicator continues to be a strength for the CMC program, scoring 100.0 percent in the prior two reviews. The organizations demonstrated strong practices in ensuring appropriate coordination of referrals.

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



*Note: The review indicator *Hospitalization Follow-Up* applied to 26 of 70 records in CY 2022, 15 of 70 records in CY 2021, and 18 of 60 records in CY 2020.
**Note: The review indicator *Coordination of Referrals* applied to 23 of 70 records in CY 2022, 31 of 70 records in CY 2021, and 20 of 60 records in CY 2020.

The graph on the next page illustrates each hospitals' overall compliance with the monitoring and service coordination standards.



Note: The review indicator *Hospitalization Follow-Up* applied to 16 of 30 records for AFCH, 8 of 30 records for CHW, and 2 of 10 for MCH.
**Note: The review indicator *Coordination of Referrals* applied to 10 of 30 records for AFCH, 7 of 30 records for CHW, and 6 of 10 for MCH.

Analysis

Aggregate results for all CMR focus areas was 89.6 percent, indicating compliant practices for the CMC program. The improvements in results from the prior review indicates that the hospitals are taking actions to improve practices.

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
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® [2]	Healthcare Effectiveness Data and Information Set
HIV	Human Immunodeficiency Virus

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

*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
MCH	Marshfield Children's Hospital
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
TPA	Third Party Administrators
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®)[3] 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,

[3] "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: Validation of Performance Improvement Projects (PIP)

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

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

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

Findings were analyzed and compiled using a binomial structure (*met* and *not met*) to assess the organization's level of compliance with the PIP protocol standards, although some standards or associated indicators may have been scored *not applicable* due to the study design or phase of implementation at the time of the review. For any findings of *not met*, the EQR team documented the missing requirements related to the findings and provided recommendations.

Each section has a specified number of scoring elements, which correlate with the *CMS EQR Protocol 1, Validation of Performance Improvement Projects.* Standard scores are presented as

the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score for each standard.

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

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

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

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

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

The CMS Protocol allows states to require MCOs to calculate and report their own performance measures, or to contract with another entity to calculate and report the measures on the MCO's behalf. For MY 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 - Compliance with Standards

Compliance with Standards review, a mandatory EQR activity, evaluates policies, procedures, and practices which affect the quality and timeliness of care and services provided to MCO members, as well as members' access to services. The MetaStar team evaluated MCOs' compliance with standards according to 42 CFR 438, Subpart E using the CMS guide, *CMS External Quality Review (EQR) Protocols, Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations, A Mandatory Protocol for External Quality Reviews (EQR).* MCOs accredited by NCQA are exempt from a full Compliance with Standards review under 42 CFR 438.360 Nonduplication of mandatory activities with Medicare or accreditation review. The Accreditation review affirms the MCO's accreditation status and evaluates compliance with the areas of the Compliance with Standards review not addressed by NCQA accreditation. During FY 21-22 MetaStar completed an *Accreditation Crosswalk* (crosswalk) as part of *DHS's Accreditation Deeming Plan* in the *Managed Care Quality Strategy*. The *Accreditation Deeming Plan* deems that a full Compliance with Standards review is duplicative for organizations with full NCQA Accreditation. The crosswalk compares the CFR Managed Care requirements to the NCQA accreditation standards, the DHS-MCO contract and annual DHS Certification Application to identify gaps in assuring full compliance with the regulations. The 2021 Medicaid Managed Care Quality Strategy is located at: 2021 Medicaid Managed Care Quality Strategy (wisconsin.gov.).

The crosswalk review assesses the strengths and opportunities for improvement of the MCO related to quality, timeliness, and access to services, including health care and members with

special health care needs. MetaStar conducted a document review to evaluate policies, procedures, and practices within the organization. The review assessed information about the MCO's NCQA accreditation results, as well as its structure, operations, and practices related to the gaps identified through the crosswalk.

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

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

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

Interview sessions 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

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

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

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.

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

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

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

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

- Screening
- Assessment
- Care Plan
- Care Coordination
- Transition Plan

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 organization's information management practices on encounter data submitted to DHS. Reviewers assessed information provided in the ISCA scoring tool, which was completed by the organization and submitted to MetaStar. Some sections of the tool may have been completed by contracted vendors, if directed by the organization. Reviewers also obtained and evaluated additional supplemental documentation specific to the organization's information systems 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 organization's information system and business operations.

Section 1: Background Information

MetaStar confirms the type of managed care program operated by the organization, 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 organization's system or repository used to store Medicaid claims and encounter data. The information submitted by the organization described the foundation of its Medicaid data systems, processes and staffing. MetaStar also assesses the stability and expertise of the organization's information system department.

Section 3: Staffing

MetaStar assesses the organization's information system department staff training and expected productivity goals.

Data Acquisition - Claims and Encounter Data Collection

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

Section 4: Security

MetaStar reviewers assess the IS security controls. The organization 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 organization manages its encounter data security processes and ensures data integrity of submissions. The reviewers also evaluate the organization's data backing and disaster recovery procedures including testing.

Section 5: Data Acquisition Capabilities

MetaStar assesses information on the organizations 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 member records. The random sample included a mix of participants who enrolled during the last year, participants who had been enrolled for more than a year, and participants who had left the program since the sample was drawn. The records were reviewed for the period of June 1, 2021-November 30, 2021.

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 12 indicators that reviewers used to evaluate care management performance:

1. Eligibility
    a. Eligibility requirements
    b. Voluntary participation
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%

Standard	Citation	BC+ and SSI Managed Care Programs CY2021						
		Anthem	*i*Care	MCW	MHS	MHWI	NHP	UHC
G5	*Resolution and notification - 42 CFR 438.408*	100.0%	100.0%	100.0%	76.9%	100.0%	76.9%	100.0%
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*	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
	options - 42 CFR 438.100(b)(2)(iii), 42 CFR 438.102						
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
**Includes results for FCMH

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%

Standard	Citation	BC+ Managed Care Programs CY2021					
		CCHP*	DHP	GHC-SCW	MCHP	Quartz	SHP
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%
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%

*Includes results for FCMH

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%

Standard	Citation	PIHP Managed Care Programs CY2021	
		CCF	WM
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%
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%

Standard	Citation	PIHP Managed Care Programs CY2021	
		CCF	WM
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%