MetaStar

External Quality Review

Calendar Year 2024

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Annual Technical Report

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

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Executive Summary

Background

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

The Code of Federal Regulations (CFR) at 42 CFR §438 requires states that operate prepaid inpatient health plans and managed care organizations to conduct external quality review of these organizations and to produce an annual technical report. To meet its obligations, the State of Wisconsin, Department of Health Services (DHS) contracts with MetaStar, Inc. Review activities are planned and implemented according to The Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols. This is the annual technical report that the State of Wisconsin must provide to the CMS related to the operation of its Medicaid managed care programs. Additionally, the report contains results of optional reviews conducted on behalf of DHS for programs that are not Medicaid managed care programs. Programs reviewed include Children with Medical Complexities, Human Immunodeficiency Virus /Acquired Immunodeficiency Syndrome (HIV/AIDS) Health Home, and Obstetric Medical Home. Reviews for the programs, Children with Medical Complexities and HIV/AIDS Health Home, evaluated the practices and requirements related to care management. The review, Obstetric Medical Home, is reported separately. See Appendix 2 for more information about external quality review and a description of the methodologies used to conduct review activities.

Scope of External Quality Review Activities

This report covers the external quality review calendar year from January 1, 2024 – December 31, 2024 (CY 2024). Mandatory review activities conducted during the year included validation of performance improvement projects, validation of performance measures, assessment of

compliance with federal standards, validation of network adequacy, and information systems capabilities assessments. MetaStar also conducted one optional activity, conducting focused studies of health care quality - care management review. Care management review assesses key areas of care management practice and also supports assessment of compliance with federal standards.

Protocol 1: Validation of Performance Improvement Projects

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

Protocol 2: Validation of Performance Measures

Validation of performance measures is a mandatory review activity, required by 42 CFR §438.358, and is conducted according to federal protocol standards. The review assesses the accuracy of performance measures reported by the managed care organizations and determines the extent to which performance measures calculated by the managed care organizations follow state specifications and reporting requirements. The DHS contract with the managed care organizations specifies the quality indicators and standard measures organizations must calculate and report.

According to 42 CFR §438.360, states have the option to utilize results from a private accreditation review to avoid duplication if the requirements are comparable to standards identified in the EQR protocols and 42 CFR §438.358. The performance measures identified by DHS for validation are Healthcare Effectiveness Data and Information Set®[1] measures and are validated by a National Committee for Quality Assurance certified auditor, then submitted to DHS. MetaStar did not validate the measures but does conduct an analysis of the reported results.

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

An assessment of compliance with federal standards, or a quality compliance review, is a mandatory activity, identified in 42 CFR §438.358, and is conducted according to federal protocol standards. Compliance standards are grouped into three general categories: Managed

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

Care Organization Standards; Quality Assessment and Performance Improvement; and Grievance Systems.

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

Protocol 4: Validation of Network Adequacy

Network Adequacy Validation is a mandatory activity, identified in 42 CFR §438.68. The review assesses the capabilities of each managed care organization's provider network to ensure each are sufficient to provide timely and accessible care to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries across the continuum of services. 42 CFR §438.68 requires states to set quantitative network adequacy standards that account for regional factors and the needs of the state's managed care programs populations. This is a new protocol planned for implementation in CY 2025.

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

Care management review is an optional review activity that assesses key areas of care management practice and helps determine an organization's level of compliance with its contract with DHS.

Care Management Review – Supplemental Security Income Program

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

health, the managed care organization must stratify members into different care management needs groups which must include a Wisconsin Interdisciplinary Care Team structure for members with the highest needs.

Care Management Review – Foster Care Medical Home

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

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

Care Management Review – Wraparound Milwaukee

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

Appendix A: Information Systems Capabilities Assessment

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

According to 42 CFR §438.360, states have the option to utilize results from a private accreditation review to avoid duplication if the requirements are comparable to standards identified in the EQR protocols and 42 CFR §438.358. Using a crosswalk identifying the requirements evaluated through an information systems capabilities assessment compared to those evaluated through the National Committee for Quality Assurance Health Plan

Accreditation, MetaStar determined that the accreditation review fully evaluates all requirements identified through Appendix A of the CMS EQR Protocol. Organizations accredited through the National Committee for Quality Assurance Health Plan Accreditation and the MCO's Healthcare Effectiveness Data and Information Set® audit, as well as the organization's ability to report Healthcare Effectiveness Data and Information Set® measures encompass the requirements. For organizations not evaluated by a National Committee for Quality Assurance certified Healthcare Effectiveness Data and Information Set® Licensed Organization, MetaStar conducts a full review.

Optional Reviews: Other Medicaid Programs

Record Review – Children with Medical Complexity

Children with Medical Complexity is a target group covered under the Medicaid-targeted case management benefit. It is administered fee-for-service for all Medicaid-enrolled members who demonstrate medical necessity for covered services. The benefit is separate from managed care organizations and prepaid inpatient health plans. This activity was requested and directed by DHS to assess the access, quality, and appropriateness of care provided to members.

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

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

The HIV/AIDS Health Home Record Review is conducted every three years. The record review was last conducted in CY 2023.

Record Review – Obstetrics Medical Home/Healthy Birth Outcomes

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

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

State-Level Analysis: Quality, Timeliness, and Access

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

- Quality: The degree to which a program increases the likelihood of desired outcomes to its members through (1) its structural and operational characteristics, (2) the provision of service that are consistent with current professional, evidenced-based knowledge, and (3) interventions for performance improvement.
- Timeliness: Reducing wait and harmful delays, and is interrelated with safety, efficiency, and patient-centeredness of care.
- Access: The timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for availably and timeliness elements.

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 are identified for each review activity.

Protocol 1: Validation of Performance Improvement Projects			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths Identified: – The organizations detailed research regarding the topic selection and its importance to members.

Protocol 1: Validation of Performance Improvement Projects			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			– Aim statements identified the focus of each project and established the necessary framework. – Project populations were clearly defined. – Variables and performance measures selected were clear indicators of performance, and were adequate to answer the project aims. – Valid and reliable data collection procedures were identified to collect appropriate data for the projects. – Improvement strategies were culturally and linguistically appropriate. Progress Identified from EQR CY 2023 Recommendations: – The managed care organizations ensured each project used the same methodology for baseline and repeat measurements. Recommendations Identified: – Conduct analysis and interpretation of the PIP results using appropriate techniques, and include an assessment of the extent to which any change in performance is statistically significant. – Present PIP results and findings in a concise and easily understood manner. – Utilize evidence-based interventions that are routinely assessed to lead to the desired improvement. – Assess the extent to which improvement strategies are successful. – Ensure projects conducted by the prepaid inpatient health plans use the same methodology for baseline and repeat measures. – Document if a significant change in performance relative to the baseline occurred.

Protocol 2: Validation of Performance Measure Validation			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**

✓	✓	✓	Strengths Identified:
			– The statewide rate for the following performance measures were at or above the 75th percentile:
			  ○ BadgerCare Plus Prenatal and Postpartum Care – Postpartum Care.
			  ○ Supplemental Security Income Hemoglobin A1c Control for Patients with Diabetes
			  ○ Foster Care Medical Home Childhood Immunization Status – Combo 3.
			  ○ Foster Care Medical Home Immunizations for Adolescents – Combo 2.
			  ○ Foster Care Medical Home Lead Screening in Children.

Protocol 2: Validation of Performance Measure Validation			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			Progress Identified from EQR CY 2023 Recommendations: – The organizations improved BadgerCare Plus rates for the following performance measures: o Childhood Immunization Status – Combo 3. o Lead Screening in Children. o Prenatal and Postpartum Care – Timeliness of Prenatal Care. o Prenatal and Postpartum Care – Postpartum Care. Recommendations Identified: – Improve BadgerCare Plus rates for: o Childhood Immunization Status – Combo 3; o Immunizations for Adolescents – Combo 2; o Lead Screening in Children; o Child and Adolescent Well-Care Visits; o Prenatal and Postpartum Care – Timeliness of Prenatal Care; o Asthma Medication Ratio (Total); o Hemoglobin A1c Control for Patients with Diabetes; o Controlling Blood Pressure; and o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – Improve Supplemental Security Income rates for: o Asthma Medication Ratio (Ages 19-64); o Follow-Up After Hospitalization for Mental Illness - 30 Days; o Follow-Up After Emergency Department Visit for Mental Illness - 30 Days; o Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; o Breast Cancer Screening; and o Cervical Cancer Screening. – Improve Foster Care Medical Home rates for: o Ambulatory Care: Emergency Department Visits; o Outpatient Mental Health Follow-Up 7 Days After Hospitalization for Mental Illness (Ages 6 - 17); o Outpatient Mental Health Follow-Up 30 Days After Hospitalization for Mental Illness (Ages 6 – 17); o Outpatient Mental Health Follow-Up 7 Days After Emergency Department Visit for Mental Illness (Ages 6 - 17); and

Protocol 2: Validation of Performance Measure Validation			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			○ Outpatient Mental Health Follow-Up 30 Days After Emergency Department Visit for Mental Illness (Ages 6 - 17).

Protocol 3: Compliance with Managed Care Regulations			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths Identified: – Organizations have systems in place to ensure the quality management program has clear and appropriate structures and includes staff and provider participation. – Organizations maintain documentation and monitoring of the required activities of the Quality Management Program. – Grievance and appeal systems are in place and include an internal grievance process, an appeal process, and access to the State's Fair Hearing system. – Members' authority, process, and timing to file grievances and appeals are included in the organizations' policies and procedures. – Policies and procedures included requirements for handling of grievances and appeals, including acknowledgement, local committee composition and requirements, and special requirements for appeals. – Organizations have recordkeeping systems in place to ensure grievances and appeals are monitored and accounted for. – Organizations' policies and procedures included requirements to reinstate benefits for reversed appeal denials. Progress Identified from EQR CY 2021 Recommendations: – Organizations issued notices of adverse benefit determination when indicated and within contract specified timeframes. Recommendations Identified: – Provide feedback to members in response to their input on quality improvement. – Ensure the Quality Assessment Performance Improvement work plan includes the plan to meet pay-for-performance goals and submission of the audited results to the Department of Health Services on time. – Ensure the Quality Assessment Performance Improvement work plans include annual Performance Improvement Projects topic selection, implementation, monitoring, and final report submission to the Department of Health Services and to the external quality review organization.

Protocol 3: Compliance with Managed Care Regulations			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			– Implement processes to ensure the timing of sending notices of adverse benefit determination meet contract requirements. – Develop processes that comply with requirements if a grievance or appeal is submitted by an individual purporting to be the member's authorized representative and the organization does not have documented consent on file. – Ensure written notice of grievance resolutions meet format and language requirements set forth in the contract. – Issue a separate written notice of appeal resolution for each adverse benefit determination appealed by a member. – Develop processes to ensure punitive action is not taken by the organization or contracted providers against anyone who requests an expedited resolution or supports a member's appeal. – Distribute member grievance and appeal rights and corresponding documents to providers and subcontractors. – Ensure providers and subcontractors have written procedures describing how members are informed of denied services and make copies for review upon request by the Department of Health Services. – Ensure processes for continuing member's benefits during the appeal process include all contract requirements.

Protocol 9: Conducting Focused Studies of Health Care Quality – Care Management Review Supplemental Security Income			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths Identified: – Member screens were comprehensive. – Members agreed to their care plans prior to its implementation. – The organizations ensured the Wisconsin Interdisciplinary Care Teams included two licensed professionals. Progress Identified from EQR CY 2023 Recommendations: – The organizations improved efforts in sharing member care plans with all required individuals. Recommendations Identified: – Ensure member screens are completed timely.

Protocol 9: Conducting Focused Studies of Health Care Quality – Care Management Review Supplemental Security Income			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			– Conduct comprehensive care planning by ensuring care plans are completed timely, are comprehensive, and are shared with all required individuals. – Provide strong care coordination by contacting members based on their needs and stratification level and providing timely and ongoing follow-up for members' needs. – Ensure care plans are reviewed and updated at least annually or when a change in members' needs. – Re-stratify members after each critical event. – Conduct timely and comprehensive transition planning for members discharging from an inpatient hospital setting. – Ensure the Wisconsin Interdisciplinary Care Team meets weekly to discuss members and has face-to-face monthly contact with members.

Protocol 9: Conducting Focused Studies of Health Care Quality – Care Management Review Foster Care Medical Home			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths Identified: – Out-of-home care health screens were comprehensive. – Initial health assessments were comprehensive. – Initial care plans were completed timely. – Ongoing care plans were reviewed and updated timely. – Care plans were comprehensive. – Transition plans were created timely. – Transition plans were reviewed and updated timely. – Transition plans were comprehensive. Progress Identified from EQR CY 2023 Recommendations: – The organization ensured initial health assessments were comprehensive. Recommendations Identified: – Conduct timely out-of-home care health screens. – Ensure initial health assessments are completed timely. – Prioritize reviewing and updating care plans within 30 days of hospitalization discharge. – Include input from all required individuals into each care plan review. – Complete timely follow-up for member needs and services. – Provide input from all required individuals into each transition plan review.

Appendix A: Information Systems Capabilities Assessment			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓		Strengths Identified: – All organizations reviewed fully met the requirements evaluated through the Healthcare Effectiveness Data and Information Set® audit. Progress Identified from EQR CY 2023 Recommendations: – Organizations demonstrated efforts between the information technology and claims departments to increase the claims auto-adjudication rate. – Organizations monitored claims from the third-party vision vendor to ensure completeness of data in the encounter submission files. – Organizations demonstrated effective procedures for submitting measure-relevant information for data entry, including checking procedures for electronic transmissions to ensure accuracy. – Organizations performed consistent oversight and validation of vendors to ensure vendors met expected performance standards. – Organizations identified and corrected incorrect extraction of data fields and delays in recognizing and/or remediating the underlying issues. – Organizations identified and corrected issues and delays related to improper identification of populations, utilization data extracts, and measure report set selection. Recommendations Identified: – All organizations fully met requirements. No recommendations were identified.

Non-Managed Care Programs – Record Review Children with Medical Complexity			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths Identified: – Program eligibility requirements were a strength for the organizations. – The organizations ensured assessments were comprehensive and completed timely. – The organizations ensured appropriate involvement in care planning. – The organizations demonstrated strengths related to ongoing monitoring and service coordination. – The organizations had strong practices in place for coordination and follow-up for member hospitalizations. Progress Identified from EQR CY 2023 Recommendations:

Non-Managed Care Programs – Record Review Children with Medical Complexity			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			– Following the CY 2023 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous review are not comparable; therefore, progress cannot be identified. Recommendations Identified: – Place priority on updating the care plan at least once every six months. – Ensure care plan goals include actions for each goal and timeframes for initiating and/or completing each action.

State Quality Strategy

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

Wisconsin DHS utilizes three types of strategies[2]:

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

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

decisions, encouraging appropriate utilization of benefits, and ensuring members receive services and supports according to their needs and preferences. These strategies involve providing culturally competent member services, objective information about care options, and support for employment.

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

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

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
Enhance Value-Based Purchasing	Protocol 2: – The statewide rates for the following measures met or exceeded the national 75th percentile benchmark and maximum pay-for-performance benchmark: ○ BadgerCare Plus Prenatal and Postpartum Care - Postpartum Care; and ○ Supplemental Security Income Hemoglobin A1c Control for Patients with Diabetes.	Protocol 2: – Focus efforts on improving the following BadgerCare Plus rates to meet or exceed the national 75th percentile benchmark and maximum pay-for-performance benchmark: ○ Childhood Immunization Status – Combo 3; ○ Immunizations for Adolescents – Combo 2; ○ Lead Screening in Children; ○ Child and Adolescent Well-Care Visits;

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
		○ Prenatal and Postpartum Care – Timeliness of Prenatal Care; ○ Asthma Medication Ratio (Total); ○ Hemoglobin A1c Control for Patients with Diabetes; ○ Controlling Blood Pressure; and ○ Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day (Total). – Focus efforts on improving the following Supplemental Security Income rates to meet or exceed the national 75th percentile benchmark and maximum pay-for-performance benchmark: ○ Asthma Medication Ratio (Ages 19-64); ○ Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); ○ Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; ○ Breast Cancer Screening; and ○ Cervical Cancer Screening.
Reduce Avoidable, Non-Value Added Care	Protocol 2: The BadgerCare Plus organizations facilitated avoidable non-value added care by meeting or exceeding national 50th-75th percentile benchmarks for: ○ Immunizations for Adolescents - Combo 2; ○ Lead Screening in Children;	Protocol 2: – To reduce preventable readmissions, BadgerCare Plus organizations should improve rates for: ○ Childhood Immunization Status – Combo 3. – To reduce preventable readmissions, Supplemental

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
	○ Child and Adolescent Well-Care Visits; ○ Prenatal and Postpartum Care - Timeliness of Prenatal Care; ○ Prenatal and Postpartum Care - Postpartum Care; ○ Asthma Medication Ratio (Total); ○ Hemoglobin A1c Control for Patients with Diabetes; ○ Controlling Blood Pressure; and ○ Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day (Total). The Supplemental Security Income organizations facilitated avoidable non-value added care by meeting or exceeding national 50th-75th percentile benchmarks for: ○ Follow-Up After Hospitalization for Mental Illness - 30 Days; ○ Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; ○ Breast Cancer Screening; and, ○ Cervical Cancer Screening. The Foster Care Medical Home organization facilitated avoidable non-value added care by meeting or exceeding national 50th-75th percentile benchmarks for: ○ Childhood Immunization Status – Combo 3; ○ Immunizations for Adolescents – Combo 2; and ○ Lead Screening in Children.	Security Income organizations should improve rates for: ○ Asthma Medication Ratio (Ages 19-64); and ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total). – To reduce preventable readmissions, the Foster Care Medical Home organization should improve rates for: ○ Ambulatory Care: Emergency Department Visits; ○ Outpatient Mental Health Follow-Up 7 Days After Hospitalization for Mental Illness (Ages 6 - 17); ○ Outpatient Mental Health Follow-Up 30 Days After Hospitalization for Mental Illness (Ages 6 – 17); ○ Outpatient Mental Health Follow-Up 7 Days After Emergency Department Visit for Mental Illness (Ages 6 - 17); and ○ Outpatient Mental Health Follow-Up 30 Days After Emergency Department Visit for Mental Illness (Ages 6 - 17). Protocol 9: – To reduce avoidable, non-value added care, organizations operating the Supplemental Security Income programs should: ○ Update care plans for members changing needs; ○ Re-stratify members after a critical event; ○ Conduct timely and comprehensive hospital discharge transition planning; and

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
		○ Ensure members receive the appropriate level of care management such as the Wisconsin Interdisciplinary Care Team program.
Enhance Care Coordination and Person-Centered Care	Protocol 1: – Organizations ensured person-centered care by selecting Performance Improvement Project topics through a comprehensive analysis of member needs, care, and services. – Organizations conducted Performance Improvement Projects that focused on improving key aspects of member care. Protocol 3: – Organizations maintained quality management programs that included member, staff, and provider participation. – Organizations have grievance and appeal systems in place that include required internal grievance processes, appeal processes, and access to the State's Fair Hearing system. Protocol 9: – The Supplemental Security Income program ensured appropriate care coordination and person-centered care by: ○ Conducting comprehensive member screens; and ○ Obtaining member agreement to the care plan prior to its implementation.	Protocol 9: – To enhance care coordination and person-centered care, organizations operating the Supplement Security Income programs should: ○ Ensure member screens are conducted timely; ○ Ensure care plans are completed timely, are comprehensive, and are shared with all required individuals; ○ Contact members based on needs and stratification level; ○ Provide timely and ongoing follow-up for member needs and requests; and ○ Ensure care plans are reviewed and updated at least annually or when a members' needs change.
Improve Health Homes	The External Quality Review Organization's evaluation of the HIV/AIDS Health Home is conducted once every three years. The previous External Quality Review Organization's evaluation of the HIV/AIDS Health Home was conducted in CY 2023.	

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
Ensure Health and Safety	Protocol 1: – Organizations ensured member health and safety by selecting Performance Improvement Project topics based on a comprehensive analysis of member needs, care, and services and that focused on improving key aspects of member care. Protocol 2: – The BadgerCare Plus organizations ensured member health and safety by meeting or exceeding national 50th-75th percentile benchmarks for: ○ Immunizations for Adolescents - Combo 2; ○ Lead Screening in Children; ○ Child and Adolescent Well-Care Visits; ○ Prenatal and Postpartum Care - Timeliness of Prenatal Care; ○ Prenatal and Postpartum Care - Postpartum Care; ○ Asthma Medication Ratio (Total); ○ Hemoglobin A1c Control for Patients with Diabetes; ○ Controlling Blood Pressure; and ○ Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day (Total). – The Supplemental Security Income organizations ensured member health and safety by meeting or exceeding national 50th-75th percentile benchmarks for: ○ Hemoglobin A1c Control for Patients with Diabetes;	Protocol 2: – To ensure health and safety, BadgerCare Plus organizations should improve rates for: ○ Childhood Immunization Status – Combo 3. – To ensure health and safety, Supplemental Security Income organizations should improve rates for: ○ Asthma Medication Ratio (Ages 19-64); and ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total). – To ensure health and safety, the Foster Care Medical Home organization should improve rates for: ○ Ambulatory Care: Emergency Department Visits; ○ Outpatient Mental Health Follow-Up 7 Days After Hospitalization for Mental Illness (Ages 6 - 17); ○ Outpatient Mental Health Follow-Up 30 Days After Hospitalization for Mental Illness (Ages 6 – 17); ○ Outpatient Mental Health Follow-Up 7 Days After Emergency Department Visit for Mental Illness (Ages 6 - 17); and ○ Outpatient Mental Health Follow-Up 30 Days After Emergency Department Visit for Mental Illness (Ages 6 - 17). Protocol 9: – To ensure members' health and safety needs, organizations operating the

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
	○ Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); ○ Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; ○ Breast Cancer Screening; and ○ Cervical Cancer Screening. – The Foster Care Medical Home organization ensured member health and safety by meeting or exceeding national 50th-75th percentile benchmarks for: ○ Childhood Immunization Status – Combo 3; ○ Immunizations for Adolescents – Combo 2; and ○ Lead Screening in Children. Protocol 3: – Organizations maintained quality management programs that included member, staff, and provider participation. Protocol 9: – Organizations demonstrated the Supplement Security Income program ensured member health and safety by: ○ Conducting comprehensive member screens to evaluate health and safety needs; and ○ Providing an intensive case management program, the Wisconsin Interdisciplinary Care Team, which comprised of two licensed health care providers.	Supplemental Security Income program should: ○ Contact members based on their needs and stratification level and providing timely and ongoing follow-up for members' needs; ○ Re-stratify members after each critical event; and ○ Ensure the case management program for members with the highest needs, the Wisconsin Interdisciplinary Care Team, meets weekly to discuss members and have face-to-face monthly contact with members.

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
Promote Member Engagement	Protocol 1: – Organizations supported member engagement by considering member and/or provider input and conducting a comprehensive analysis of member needs, care, and services when selecting Performance Improvement Project topics. Protocol 3: – Organizations maintained quality management programs that included member, staff, and provider participation. Protocol 9: – Organizations promoted member engagement by ensuring member agreement to care plans prior to implementation in the Supplemental Security Income program.	Protocol 9: – To support member engagement, organizations operating the Supplemental Security Income programs should provide strong care coordination by contacting members based on their needs and stratification level and providing timely and ongoing follow-up for members' needs.
Enable Infrastructure for Health Information	Appendix A: – All organizations evidenced information systems that are capable of collecting, analyzing, integrating, and reporting reliable and accurate data.	Appendix A: – No recommendations related to this strategy were identified.

Introduction and Overview

This report covers mandatory and optional external quality review (EQR) activities conducted by the external quality review organization (EQRO), MetaStar, Inc., for the calendar year from January 1, 2024 - December 31, 2024 (CY 2024).

The following programs are evaluated through this report:

- BadgerCare Plus (BC+);
- Supplemental Security Income (SSI);
- Foster Care Medical Home (FCMH);
- Wraparound Milwaukee (WM);
- Children Come First (CCF); and
- Children with Medical Complexities (CMC).

Acronyms and Abbreviations

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

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

As of November 2024, enrollment was as follows:

Program	Enrollment
BadgerCare Plus	837,719
Supplemental Security Income Medicaid	52,727
Foster Care Medical Home	2,777
Wraparound Milwaukee	0*
Children Come First	0**

*Wraparound Milwaukee ceased program operations in CY 2024.
**Children Come First ceased program operations in CY 2023.

Current enrollment data is available at the following DHS website:

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

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

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

Managed Care Organization	Program(s)	Accreditation Organization and Status
Anthem Blue Cross and Blue Shield Health Plan (Anthem)	BC+ SSI	National Committee for Quality Assurance (NCQA) Accreditation Obtained: – Health Plan Accreditation ○ Accredited:10/18/2024 - 10/18/2027 – Health Equity Accreditation ○ Accredited: 11/20/2023 - 11/20/2026 – Health Equity Accreditation Plus ○ Accredited: 11/20/2023 - 11/20/2026
Chorus Community Health Plan, Inc. (CCHP)	BC+ FCMH	NCQA Accreditation Obtained: – Health Plan Accreditation ○ Accredited: 12/26/2023 - 12/26/2026 – Health Equity Accreditation ○ Accredited: 7/17/2023 - 7/17/2026
Dean Health Plan, Inc. (DHP)	BC+	NCQA Accreditation Obtained: – Health Plan Accreditation ○ Accredited: 5/1/2023 - 5/1/2026 – Health Equity Accreditation ○ Accredited. 8/24/2023 - 8/24/2026
Group Health Cooperative of Eau Claire (GHC-EC)	BC+ SSI	NCQA Accreditation Obtained: – Health Plan Accreditation ○ Accredited: 9/5/2023 - 9/5/2026 – Multicultural Healthcare Distinction ○ Accredited: 8/30/2022 – 8/30/2025
Group Health Cooperative of South-Central Wisconsin (GHC-SCW)	BC+	NCQA Accreditation Obtained: – Health Plan Accreditation ○ Accredited: 11/21/2023 - 11/21/2026 – Health Equity Accreditation ○ Accredited: 8/3/2023 - 8/3/2026
Independent Care Health Plan (*i*Care)	BC+ SSI	NCQA Accreditation Obtained: – Health Plan Accreditation ○ Accredited: 11/29/2023 - 11/29/2026 – Health Equity Accreditation ○ Accredited: 12/4/2023 - 12/4/2026
MercyCare Health Plans (MCHP)	BC+	NCQA Accreditation Obtained: – Health Plan Accreditation ○ Accredited: 12/18/2023 - 12/18/2026 – Health Equity Accreditation (Provisional) ○ Accredited: 9/23/2024 - 12/23/2025

Managed Care Organization	Program(s)	Accreditation Organization and Status
MHS Health Wisconsin (MHS)	BC+ SSI	NCQA Accreditation Obtained: – Health Plan Accreditation ○ Accredited: 8/12/2022 - 8/12/2025 – Health Equity Accreditation ○ Accredited: 10/17/2023 - 10/17/2026
Molina HealthCare of Wisconsin (MHWI)	BC+ SSI	NCQA Accreditation Obtained: – Health Plan Accreditation ○ Accredited: 6/20/2023 - 6/20/2026 – Health Equity Accreditation ○ Accredited: 8/30/2023 - 8/30/2026
My Choice Wisconsin (MCW)	BC+ SSI	NCQA Accreditation Obtained: – Health Plan Accreditation (Interim) ○ Accredited: 11/14/2023 - 5/14/2025 – Health Equity Accreditation ○ Accredited: 12/5/2023 - 12/5/2026
Network Health Plan (NHP)	BC+ SSI	NCQA Accreditation Obtained: – Health Plan Accreditation ○ Accredited: 9/6/2023 - 9/6/2026 – Health Equity Accreditation ○ Accredited: 12/6/2023 - 12/6/2026
Quartz Health Solutions, Inc. (Quartz)	BC+ SSI	NCQA Accreditation Obtained: – Health Plan Accreditation ○ Accredited: 11/7/2023 - 11/7/2026 – Health Equity Accreditation ○ Accredited: 9/29/2023 - 9/29/2026
Security Health Plan of Wisconsin, Inc. (SHP)	BC+ SSI	NCQA Accreditation Obtained: – Health Plan Accreditation ○ Accredited: 8/8/2024 - 5/12/2026 – Health Equity Accreditation ○ Accredited: 11/13/2023 - 11/13/2026
United Healthcare Community Plan (UHC)	BC+ SSI	NCQA Accreditation Obtained: – Health Plan Accreditation ○ Accredited: 2/8/2023 - 2/8/2026 – Health Equity Accreditation ○ Accredited: 9/28/2022 - 9/28/2025
Prepaid Inpatient Health Plan	**Program(s)**	**Accreditation Organization and Status**
Children Come First (CCF)	Children with mental health needs.	Not Accredited
Wraparound Milwaukee (WM)	Children with mental health needs.	Not Accredited

Non-Managed Care Benefit Program	Program(s)	Accreditation Organization and Status
Children's Hospital of Wisconsin	CMC	Not Accredited
Marshfield Children's Hospital	CMC	Not Accredited
UW Health-American Family Children's Hospital	CMC	Not Accredited

Organization-Level Analysis: Quality, Timeliness, Access

The Centers for Medicare & Medicaid Services (CMS) guidelines regarding this annual technical report direct the EQRO to provide an assessment of each MCOs' strengths and weaknesses with respect to quality, timeliness, and access to health care services. The Medicaid MCOs and prepaid inpatient health plans (PIHP) included in this report do not provide long-term services and supports. Compliance with these review activities provides assurances that MCOs are meeting requirements related to access, timeliness, and quality of services, including health care. The analysis included in this section of the report provides assessment of strengths, progress, and recommendations for improvement for each MCO. Progress in this section includes any identified improvement and is not limited to the recommendations made by the EQRO in the prior review. The following tables identify the mandatory review activities, scope of activities, and findings from the assessments of quality, timeliness, and access to health care services for the programs each MCO operates.

Anthem Blue Cross and Blue Shield Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 122,215 SSI: 7,199
Findings	
Protocol 1: Validation of Performance Improvement Projects (PIPs) • *Prenatal and Postpartum Care* • *Follow-Up After High-Intensity Care for Substance Use Disorder*	**Strengths Identified:** – 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 project population in relation to the aim statement for both projects. – The organization selected project variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the project data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the project data and interpret the results for one project. – The organization utilized methodology that was likely to demonstrate significant and sustained improvement for both projects. – The organization demonstrated significant improvement that may likely be the result of selected interventions for one project.

Anthem Blue Cross and Blue Shield Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 122,215 SSI: 7,199
Findings	
	Progress Identified from EQRO CY 2023 Recommendations: – The organization included evidence of statistical analysis to assess differences between the initial and repeat measurements. – The organization presented results that were easily understood and related to the aim statement. **Recommendations Identified:** – Ensure the goal for the measurement year is an improvement over the previous year's results. – Document analysis of the data according to the data analysis plan. – Document all stages of a continuous cycle of improvement in the project report. – Identify how the organization ensures strategies are culturally and linguistically appropriate in future project reports. – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the Supplemental Security Income program: o Hemoglobin A1c Control for Patients with Diabetes; and o Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications. **Progress Identified from EQRO CY 2023 Recommendations:** – Improved BadgerCare Plus rates for: o Lead Screening in Children; o Prenatal and Postpartum Care - Timeliness of Prenatal Care; and, o Prenatal and Postpartum Care - Postpartum Care. – Improved the Supplemental Security Income rate for: o Follow-Up After Hospitalization for Mental Illness - 30 Days. **Recommendations Identified:** – The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program: o Childhood Immunization Status - Combo 3; o Immunizations for Adolescents - Combo 2; o Lead Screening in Children; o Child and Adolescent Well-Care Visits; o Prenatal and Postpartum Care - Postpartum Care; o Asthma Medication Ratio (Total); o Hemoglobin A1c Control for Patients with Diabetes; o Controlling Blood Pressure; and o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – The following rates demonstrated an opportunity for improvement for the Supplemental Security Income program: o Asthma Medication Ratio (Ages 19-64);

Anthem Blue Cross and Blue Shield Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 122,215 SSI: 7,199
Findings	
	○ Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); ○ Breast Cancer Screening; and ○ Cervical Cancer Screening.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths Identified:** – The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members. **Progress Identified from EQRO CY 2021 Recommendations:** – The organization revised documents to specify one level of appeal for members. – The organization implemented a process to ensure all providers receive the *Member Grievance and Appeals Guide and Ombudsman Brochure* as required. – The organization amended documentation to ensure all required recordkeeping elements are retained for grievances and appeals. **Recommendations Identified:** – Develop and implement a process to document and communicate member feedback obtained by the quality committee. – Include the submission process of the annual Performance Improvement Project reports to the External Quality Review Organization in the Quality Improvement workplan. – Update documentation to include that the member advocate must attempt to resolve issues and concerns without formal hearings or reviews when possible with the member. – Amend documentation to include all circumstances in which the organization may send a notice no later than the date of action for termination, suspension, or reduction of previously authorized Medicaid-covered services. – Revise documentation to ensure a final written decision is sent to members for grievances resolved during the initial phone call to the organization. – Ensure documentation indicates the organization must issue a separate written notice of appeal resolution for each adverse benefit determination appealed by a member. – Update documentation to ensure no punitive action is taken by a contracted provider against anyone who requests an expedited resolution of an appeal or supports a member's appeal. – Amend appeal policies and procedures to include all the requirements for when the member's benefits must continue. – Update documentation to include if the organization fails to adhere to the notice and timing requirements of appeal and grievances, the member is deemed to have exhausted the organization's appeal process and the member may initiative a State Fair Hearing.

Anthem Blue Cross and Blue Shield Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 122,215 SSI: 7,199
Findings	
	– Ensure the organization's appeal and grievance records distinguish BadgerCare Plus or Supplemental Security Income members from commercial members. If the organization serves both BadgerCare Plus and Supplemental Security Income members, the records must distinguish between the two populations.
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths Identified:** – No strengths were identified. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – Conduct member screens timely. – Complete care plans within the required timeframes. – Include all required elements in the care plan. – Distribute care plans to all required team members. – Ensure members are contacted once every 12 months or more based on their stratification. – Provide timely follow-up for member requests and needs. – Conduct a comprehensive care plan review at least once every 12 months. – Update the member care plan for changing member needs. – Ensure members are re-stratified after experiencing a critical event. – Contact members within five business days of discharge from a hospital. – Ensure transitional care follow-up includes a review of hospital discharge information within the required timeframe. – Include a minimum of two licensed health care providers in the Wisconsin Interdisciplinary Care Team. – Ensure the Wisconsin Interdisciplinary Care Team meets at minimum weekly to discuss the member. – Have the Wisconsin Interdisciplinary Care Team conduct a once a month face-to-face visit with the member.
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization fully met all Information System categories evaluated in the previous review. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.

Anthem Blue Cross and Blue Shield Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 122,215 SSI: 7,199
Findings	
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Chorus Community Health Plan, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, FCMH	BC+: 118,478 FCMH: 2,777
Findings	
Protocol 1: Validation of Performance Improvement Projects *BadgerCare Plus* • *Prenatal and Postpartum Care* • *Childhood Immunization Status*	**Strengths Identified:** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization clearly identified the project population in relation to the aim statement for both projects. – The organization selected project variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the project data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the project 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 one project. – The organization utilized methodology that was likely to demonstrate significant and sustained improvement for one project. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization included a list of data collection personnel and relevant qualifications for staff collecting data from the medical record review. – The organization conducted an inter-rater and intra-rater reliability process for personnel collecting data from the medical record review. – The organization ensured project results were compared across other entities, such as different organizations or sub-groups. – The strategy was designed to identify potential project barriers and a plan to address those barriers. – The organization implemented a Plan-Do-Study-Act approach that was used to test the improvement strategies. **Recommendations Identified:** – Ensure the aim statement clearly specifies the improvement strategies for the project. – Include all required criteria in the aim statement, ensuring it is answerable. – Explain the rationale for the selected improvement strategies, including how the strategies are evidence-based. – Continue to design a methodologically sound performance improvement project to ensure project results demonstrate an improvement from the baseline rate identified in the project's aim statement.

Chorus Community Health Plan, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, FCMH	BC+: 118,478 FCMH: 2,777
Findings	
Protocol 1: Validation of Performance Improvement Projects *Foster Care Medical Home* • *Mental Health Evaluations* • *Care Transitions*	**Strengths Identified:** – 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 project population in relation to the aim statement for both projects. – The organization selected project variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the project data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the project data and interpret the results for one project. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization ensured the aim statement clearly specified the improvement strategies for the project. – The aim statement included all required criteria, ensuring it was answerable. – The organization specified the frequency of data collection for all project measures. – The data analysis plan was established and clearly documented to ensure that appropriate data would be available for the project. **Recommendations Identified:** – Ensure data analysis is conducted in accordance with the data analysis plan. – Include an analysis of the baseline and repeat measurements of the project outcomes. – Include evidence of statistical analysis to assess differences between the initial and repeat measurements. – Perform and document an analysis comparing the results to other entities or population subgroups. – Present results in a concise and easily understood manner. – Include lessons learned or opportunities for improvement based on the data analysis when the aim is not achieved. – Explain the rationale for the selected improvement strategies, including how the strategies are evidence-based. – Document a continuous cycle of improvement used to test a selected improvement strategy. – Develop a plan to address variables encountered during the project. – Using data analysis and interpretation, assess the extent to which the improvement strategies were successful. – Ensure the same methodology is used for baseline and repeat measurements.

Chorus Community Health Plan, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, FCMH	BC+: 118,478 FCMH: 2,777
Findings	
	– Design a methodologically sound performance improvement project to ensure project results demonstrate an improvement from the baseline rate identified in the project's aim statement. – Develop and implement improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the BadgerCare Plus program: o Lead Screening in Children; o Prenatal and Postpartum Care - Postpartum Care; o Asthma Medication Ratio (Total); and o Hemoglobin A1c Control for Patients with Diabetes; – The following rates were strengths for the Foster Care Medical Home program: o Childhood Immunization Status – Combo 3; o Immunizations for Adolescents – Combo 2; and o Lead Screening in Children. **Progress Identified from EQRO CY 2023 Recommendations:** - Improved the BadgerCare Plus rate for Lead Screening in Children. **Recommendations Identified:** – The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program: o Childhood Immunization Status - Combo 3; o Immunizations for Adolescents - Combo 2; o Child and Adolescent Well-Care Visits; o Prenatal and Postpartum Care - Timeliness of Prenatal Care; o Controlling Blood Pressure; and o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – The following rates demonstrated an opportunity for improvement for the Foster Care Medical Home program: o Ambulatory Care: Emergency Department (ED) Visits; o Outpatient Mental Health Follow-Up 7 Days After Hospitalization for Mental Illness (Ages 6 - 17); o Outpatient Mental Health Follow-Up 30 Days After Hospitalization for Mental Illness (Ages 6 – 17); o Outpatient Mental Health Follow-Up 7 Days After ED Visit for Mental Illness (Ages 6 - 17); and o Outpatient Mental Health Follow-Up 30 Days After ED Visit for Mental Illness (Ages 6 - 17).

Chorus Community Health Plan, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, FCMH	BC+: 118,478 FCMH: 2,777
Findings	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths Identified:** – The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members. **Progress Identified from EQRO CY 2021 Recommendations:** – The organization revised documents to include the issuance of written notification of adverse benefit determinations to members as well as providers in the following circumstances: o When services are denied, terminated, reduced, or suspended; o When claims are denied; and o When the organization is unable to decide on a service authorization request in a timely manner. – The organization amended grievance and appeal documents to specify that parties to an appeal may include a representative of a deceased enrollee's estate. – The organization amended utilization management documents to include the requirement to authorize or provide disputed services as expeditiously as the member's health condition requires, but no later than 72 hours from the date the organization receives notification that its appeals process or State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending. **Recommendations Identified:** – Ensure the quality improvement workplan includes submission of the audited pay for performance results to the Wisconsin Department of Health Services, and the timeframe for submitting the results. – Ensure the quality improvement workplan includes submission of the annual Performance Improvement Project final reports to the External Quality Review Organization. – Update documentation to include that Member Advocates must attempt to resolve issues and concerns without formal hearings or reviews when possible with the member. – Update documentation to include the requirement to mail a notice of termination, suspension, or reduction of previously authorized Medicaid covered services at least 10 days before the date of action. – Amend documentation to include all occurrences in which the organization may send a notice of adverse benefit determination. – Revise documentation to include when the organization may shorten the period of advance notice to five days before the action. – Ensure a written acknowledgement of all grievances are sent to members within 10 business days of receipt. – Update processes to include the contract requirements if a grievance or appeal is submitted by an individual purporting to be the member's authorized representative and the organization does not have the documented consent for the individual to act as the member's representative on file.

Chorus Community Health Plan, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, FCMH	BC+: 118,478 FCMH: 2,777
Findings	
	– Amend documentation to include the language and format requirements to ensure written grievance resolution letters are compliant. – Ensure documentation indicates the organization must issue a separate written notice of appeal resolution for each adverse benefit determination appealed by a member. – Revise documentation to ensure members are allotted 90 calendar days, including the timeframe to receive the organization's notice to uphold the adverse benefit determination, to request a State Fair Hearing. – Amend documentation to identify the materials that are required to be provided upon request for information regarding a State Fair Hearing. – Update documents to ensure no punitive action is taken by a contracted provider against anyone who requests an expedited resolution of an appeal or supports a member's appeal. – Ensure member grievance and appeal rights and corresponding documents are distributed to providers and subcontractors. – Ensure providers and subcontractors have written procedures describing how members are informed of denied services, and have copies for review if requested by the Wisconsin Department of Health Services. – Update internal documentation to include a written process or procedure used to obtain and respond to member input on quality improvement. – Revise processes to ensure a final written decision is sent for grievances resolved during the initial phone call to the organization.
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Protocol 9: Conducting Focused Studies of Health Care Quality – Foster Care Medical Home *Care Management Review*	**Strengths Identified:** – Out-of-home care health screens were comprehensive. – Initial health assessments were comprehensive. – Initial care plans were completed timely. – Ongoing care plans were reviewed and updated timely. – Care plans were comprehensive. – Transition plans were created timely. – Transition plans were reviewed and updated timely. – Transition plans were comprehensive. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization ensured initial health assessments were comprehensive. **Recommendations Identified:** – Conduct timely out-of-home care health screens. – Ensure initial health assessments are completed timely. – Prioritize reviewing and updating care plans within 30 days of hospitalization discharge. – Include input from all required individuals into each care plan review. – Complete timely follow-up for member needs and services. – Provide input from all required individuals into each transition plan review.

Chorus Community Health Plan, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, FCMH	BC+: 118,478 FCMH: 2,777
Findings	
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization fully met all Information System categories evaluated in the previous review. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Dean Health Plan, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+	BC+: 39,378
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Childhood Immunization Status*	**Strengths Identified:** – 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 project population in relation to the aim statement for both projects. – The organization selected project variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the project data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the project data and interpret the results for both projects. – The organization utilized methodology that was likely to demonstrate significant and sustained improvement for one project. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – Assess the success of each individual improvement strategy and document the assessment in future project reports. – Ensure sustained improvement is demonstrated through repeated measurements over time for continuing projects. – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the BadgerCare Plus program:

Dean Health Plan, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+	BC+: 39,378
Findings	
	○ Immunizations for Adolescents - Combo 2; ○ Prenatal and Postpartum Care - Timeliness of Prenatal Care; and ○ Prenatal and Postpartum Care - Postpartum Care. **Progress Identified from EQRO CY 2023 Recommendations:** – Improved the BadgerCare Plus rate for Prenatal and Postpartum Care - Postpartum Care. **Recommendations Identified:** – The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program: ○ Childhood Immunization Status - Combo 3; ○ Lead Screening in Children; ○ Child and Adolescent Well-Care Visits; ○ Asthma Medication Ratio (Total); ○ Hemoglobin A1c Control for Patients with Diabetes; ○ Controlling Blood Pressure; and ○ Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths Identified:** – The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members. **Progress Identified from EQRO CY 2021 Recommendations:** – The organization updated documents to include the following: ○ Issuance of written notification of adverse benefit determinations to members and providers when claims are denied; ○ The provision of written notice to members when a decision-making timeframe is extended; and ○ The circumstances under which the organization may extend the timeframe to resolve a grievance or appeal. **Recommendations Identified:** – Develop and implement a process to provide feedback to members in response to their input on quality improvement. – Include the submission of the audited pay-for-performance results to the Wisconsin Department of Health Services on the quality improvement workplan, and the timeframe for submitting the results. – Ensure a notice of termination, suspension, or reduction of previously authorized Medicaid-covered services is mailed at least 10 days before the date of action. – Develop and implement a process to outline the situations a notice of termination, suspension, or reduction of previously covered Medicaid services may be sent to the member no later than the date of action.

Dean Health Plan, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+	BC+: 39,378
Findings	
	– Include the information for when the organization may shorten the period for advanced notice of an adverse benefit determination to five days before the date of action. – Update processes to include requirements if a grievance or appeal is submitted by an individual purporting to be the member's authorized representative and the organization does not have the documented consent of the member on file for the individual to act as the member's representative. – Develop and implement a process to specify a separate written notice of appeal resolution is issued for each adverse benefit determination appealed by a member. – Amend documents to state the specific materials regarding a State Fair Hearing that must be provided to the Wisconsin Department of Health Services. – Ensure punitive action is not taken against anyone who requests an expedited resolution of an appeal or supports a member's appeal. – Place priority in implementing a process to distribute the *Ombudsman Brochure* and the *HMO and PIHP Member Grievances and Appeal Guide* to gatekeepers, providers, subcontractors, and independent practice associations. – Implement a process that the organization make copies of the gatekeeper's, provider's, subcontractor's, and independent practice association's grievance procedures available for review upon request by the Wisconsin Department of Health Services. – Amend appeal policies and procedures to specify continuation of benefits during required occurrences. – Develop and implement an appeal process to indicate benefits must continue until one of the situations identified in the contract occur. – Ensure the appeal process specifies the disputed services must be authorized and provided by the organization promptly and expeditiously, but no later than 72 hours from the date it receives notice reversing the determination.
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization fully met all Information System categories evaluated in the previous review. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Group Health Cooperative of Eau Claire	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 45,080 SSI: 2,888
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Follow-Up After Hospitalization for Mental Illness*	**Strengths Identified:** – 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 project population in relation to the aim statement for both projects. – The organization selected project variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the project 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. – The organization utilized methodology that was likely to demonstrate significant and sustained improvement for one project. – The organization demonstrated significant improvement that may likely be the result of selected interventions for one project. **Progress Identified from EQRO CY 2023 Recommendations:** – Statistical evidence that the observed improvement was the result of the intervention was documented in the report. **Recommendations Identified:** – Conduct statistical testing analysis for all projects and aim statements in future project reports. – Clearly identify the baseline rate and maintain the rate when analyzing baseline and repeat measurements. – Document all steps of the Plan-Do-Study-Act cycle in future project reports. – Focus efforts to achieve improvement in all projects. – Ensure sustained improvement is demonstrated through repeated measurements over time for all continuing projects.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the BadgerCare Plus program: o Prenatal and Postpartum Care - Timeliness of Prenatal Care; o Prenatal and Postpartum Care - Postpartum Care; o Asthma Medication Ratio (Total); o Hemoglobin A1c Control for Patients with Diabetes; and o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – The following rates were strengths for the Supplemental Security Income program: o Asthma Medication Ratio (Ages 19-64); and o Hemoglobin A1c Control for Patients with Diabetes.

Group Health Cooperative of Eau Claire	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 45,080 SSI: 2,888
Findings	

	Progress Identified from EQRO CY 2023 Recommendations:
	– Improved the Supplemental Security Income rate for:
	  ○ Hemoglobin A1c Control for Patients with Diabetes.
	
	Recommendations Identified:
	– The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program:
	  ○ Childhood Immunization Status - Combo 3;
	  ○ Immunizations for Adolescents - Combo 2;
	  ○ Lead Screening in Children;
	  ○ Child and Adolescent Well-Care Visits; and
	  ○ Controlling Blood Pressure.
	– The following rates demonstrated an opportunity for improvement for the Supplemental Security Income program:
	  ○ Follow-Up After Hospitalization for Mental Illness - 30 Days (Total);
	  ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total);
	  ○ Hemoglobin A1c Control for Patients with Diabetes;
	  ○ Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; and
	  ○ Cervical Cancer Screening.

Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	The organization's last Compliance with Standards Review was conducted in CY 2022. The organization became Accredited by NCQA in CY 2023 and will participate in the Accreditation Desk Review in CY 2025.
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths Identified:** – No strengths were identified. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – Conduct timely screens. – Complete care plans within the required timeframes. – Ensure care plans are comprehensive. – Share the care plans with all required persons. – Contact the members based on their stratification levels. – Provide timely follow-up of identified member needs. – Update the member care plan at minimum once every 12 months. – Update the member care plan for changing member needs. – Ensure timely transition planning following a hospitalization. – Complete timely transition care follow-up of hospital discharge information.

Group Health Cooperative of Eau Claire	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 45,080 SSI: 2,888
Findings	
	– Ensure the Wisconsin Interdisciplinary Care Team meets at least weekly to discuss the member. – Complete monthly face-to-face visits with the Wisconsin Interdisciplinary Care Team and member.
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2022 Recommendations:** – The organization demonstrated efforts between the information technology and claims department to increase the claims auto-adjudication rate. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.

Group Health Cooperative of South-Central Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+	BC+: 6,894
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Well-Child Visits*	**Strengths Identified:** – 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 project population in relation to the aim statement for both projects. – The organization selected project variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the project data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the project data and interpret the results for one project. – The organization demonstrated significant improvement that may likely be the result of selected interventions one project. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization included the qualifications of staff conducting medical record reviews in the project's report. – The organization conducted statistical testing on the project's baseline and repeat measurements to determine statistical significance. – The organization designed a methodologically sound performance improvement project to demonstrate improvement from baseline to remeasurement. – The organization included statistical evidence that observed improvement is the result of the interventions.

Group Health Cooperative of South-Central Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+	BC+: 6,894
Findings	
	Recommendations Identified: – Ensure project results are compared across other entities, such as different organizations or sub-groups. – Ensure final project results are concise and easily understood. – Ensure improvement strategies are evidence based. – Utilize and document a Plan-Do-Study-Act approach to test the selected improvement strategies. – Focus efforts on improving results to gain quantitative evidence of improvement through repeated measurements each year of a continuing project.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the BadgerCare Plus program: o Immunizations for Adolescents - Combo 2; o Hemoglobin A1c Control for Patients with Diabetes; and, o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program: o Childhood Immunization Status - Combo 3; o Lead Screening in Children; o Child and Adolescent Well-Care Visits; o Prenatal and Postpartum Care - Timeliness of Prenatal Care; o Prenatal and Postpartum Care - Postpartum Care; o Asthma Medication Ratio (Total); and o Controlling Blood Pressure.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths Identified:** – The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members. – The organization demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to the Wisconsin Department of Health Services review for grievances and to the State Fair Hearing system for appeals, when decisions are adverse to the member. **Progress Identified from EQRO CY 2021 Recommendations:** – The organization evaluated the overall effectiveness of the quality program annually to determine whether the program demonstrated improvement. – The organization implemented a process to issue notices of adverse benefit determination when previously authorized services are reduced, terminated, or suspended, and when new service requests are denied.

Group Health Cooperative of South-Central Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+	BC+: 6,894
Findings	
	– The organization amended documents to address the ability of members and providers to request an extension to the standard authorization decision-making timeframe, and the right to file a grievance if they disagree with the decision to extend the timeframe. – The organization revised documents to identify and incorporate the following: o A member's ability to initiate a State Fair Hearing if the organization fails to adhere to the notice and timing requirements for resolving appeals; o The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner, if possible; and, o That punitive action will not be taken against anyone who requests an expedited resolution of an appeal or supports a member's appeal. **Recommendations Identified:** – Ensure the quality improvement workplan includes submission of the audited pay-for-performance results to the Wisconsin Department of Health Services and the timeframe for submitting the results. – Ensure the quality improvement workplan includes submission of the annual Performance Improvement Project topic selection, implementation, monitoring, and final report to the Wisconsin Department of Health Services and to the external quality review organization. – Update documentation to reference language and formatting requirements for grievance resolution notices. – Revise grievance and appeal documentation to ensure members are able to request a State Fair Hearing no later than 90 calendar days from the date of receipt of the notice of the organization's decision to uphold the adverse benefit determination, and ensure the date of receipt of the notice is within five calendar days of the date the notice was mailed. – Develop a process that details the timing of sharing the *Ombudsman Brochure* and the *HMO and PIHP Member Grievances and Appeal Guide* to the organization's gatekeepers, providers, subcontractors, and independent practice associations. – Develop a process to assure the organization's gatekeepers, providers, subcontractors, and independent practice associations have written procedures for describing how members are informed of denied services, and that the organization make copies of the grievance procedures available for review upon request by the Wisconsin Department of Health Services. – Amend grievance and appeal policies and procedures to include the following requirements for continuation of benefits: o When a member files an appeal in a timely manner; o Services were ordered by an authorized provider; o The period covered by the original authorization has not expired; o The member or their authorized representative timely files for continuation of benefits; and,

Group Health Cooperative of South-Central Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+	BC+: 6,894
Findings	
	○ The organization may pursue reimbursement from the member for the cost of services provided while the managed care organization appeal or State Fair Hearing was pending, if the Division of Hearings and Appeals upholds the organization's adverse benefit determination.
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization fully met all Information System categories evaluated in the previous review. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Independent Care Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 27,593 SSI: 8,879
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Controlling Blood Pressure*	**Strengths Identified:** – 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 project population in relation to the aim statement for one project. – The organization selected project variables and performance measures that were clear indicators of performance for one project. – The organization used valid and reliable procedures to collect the project data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the project data and interpret the results for one project. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization analyzed the data according to the data analysis plan and explained any deviation from the plan when warranted.

Independent Care Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 27,593 SSI: 8,879
Findings	
	– The organization documented a continuous cycle of improvement used to test the selected improvement strategy. **Recommendations Identified:** – Clearly define the inclusion and exclusion criteria for the study population to ensure the data collection approach captures all members to whom the aim statement applies. – Ensure variables are adequate to answer the identified project question. – Include statistical analysis for all aims in future project reports. – Present findings in a concise and easily understood manner in future project reports. – Document potential follow-up activities in future project reports. – Design a methodologically sound project to demonstrate improvement from baseline to remeasurement. – Implement an intervention that is likely to result in performance improvement. – Ensure sustained improvement is demonstrated through repeated measurements over time for continuing projects. – Enact selected improvement strategies with a statistically significant portion of the study population in order to achieve the desired improvement in outcomes of care. – Implement improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the BadgerCare Plus program: o Lead Screening in Children; and o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – The following rate was a strength for the Supplemental Security Income program: o Follow-Up After Hospitalization for Mental Illness - 30 Days (Total). **Progress Identified from EQRO CY 2023 Recommendations:** – Improved the BadgerCare Plus rate for: o Childhood Immunization Status - Combo 3. – Improved Supplemental Security Income rates for: o Follow-Up After Hospitalization for Mental Illness - 30 Days; and o Hemoglobin A1c Control for Patients with Diabetes. **Recommendations Identified:** – The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program: o Childhood Immunization Status - Combo 3; o Immunizations for Adolescents - Combo 2; o Child and Adolescent Well-Care Visits; o Prenatal and Postpartum Care - Timeliness of Prenatal Care;

Independent Care Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 27,593 SSI: 8,879
Findings	
	○ Prenatal and Postpartum Care - Postpartum Care; ○ Asthma Medication Ratio (Total); ○ Hemoglobin A1c Control for Patients with Diabetes; and ○ Controlling Blood Pressure. – The following rates demonstrated an opportunity for improvement for the Supplemental Security Income program: ○ Asthma Medication Ratio (Ages 19-64); ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); ○ Hemoglobin A1c Control for Patients with Diabetes; ○ Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; ○ Breast Cancer Screening; and ○ Cervical Cancer Screening.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths Identified:** – The organization demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to the Wisconsin Department of Health Services review for grievances and to the State Fair Hearing system for appeals, when decisions are adverse to the member. **Progress Identified from EQRO CY 2021 Recommendations:** – The organization updated the membership of the Quality Improvement Committee to include membership from a variety of disciplines. – The organization updated documentation to ensure providers or authorized representatives may request an appeal, file a grievance, or request a State Fair Hearing on behalf of the member. – The organization amended documents to include the ability of members and providers to request an extension to the standard authorization decision-making timeframe, and the right to file a grievance if they disagree with the decision to extend the timeframe. – The organization ensured the *HMO and PIHP Grievances and Appeals Guide* is provided to gatekeepers, providers, subcontractors, and independent practice associations as required. – The organization updated documentation to include the requirement that if the health plan or the Division of Hearings and Appeals reverses a decision to deny authorization of services, and the member received the disputed services while the appeal is pending, the health plan must pay for those services. – The organization revised internal documentation to include: ○ The requirement for the organization to attempt to resolve issues and concerns without formal hearings or reviews whenever possible; ○ The timeframe for members to request a State Fair Hearing after receiving the organization's notice of resolution; ○ The provision of relevant materials regarding a State Fair Hearing upon request, to the appropriate parties within five business days.

Independent Care Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 27,593 SSI: 8,879
Findings	
	Recommendations Identified: – Develop and implement a process to document and communicate member feedback obtained by the quality committee. – Include submission of pay-for-performance results to the Wisconsin Department of Health Services, and the timeframe for submitting the results in the Quality Improvement workplan. – Revise documentation to include when the organization may shorten the period for advanced notice of an adverse benefit determination to five days before the date of action. – Revise processes to ensure a final written decision is sent to members for grievances resolved during the initial phone call to the organization. – Ensure contracted providers do not take punitive action against anyone who requests an expedited resolution of appeal or supports a member's appeal.
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths Identified:** – No strengths were identified. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – Conduct member screens timely. – Ensure screens include all required elements. – Complete care plans within the required timeframes. – Include all required elements in the care plan. – Distribute care plans to all required team members. – Ensure members are contacted once every 12 months or more based on their stratification. – Conduct a comprehensive care plan review at least once every 12 months. – Update the member care plan for changing member needs. – Ensure members are re-stratified after experiencing a critical event. – Contact members within five business days of discharge from a hospital. – Ensure transitional care follow-up includes a review of hospital discharge information within the required timeframe. – Ensure the Wisconsin Interdisciplinary Care Team meets with members face-to-face once per month.
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2022 Recommendations:**

Independent Care Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 27,593 SSI: 8,879
Findings	
	– The organization monitored claims from the third-party vision vendor to ensure completeness of data in the encounter submission files. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

MercyCare Health Plans	
Programs Operated	**CY 2024 Enrollment by Program**
BC+	BC+: 12,251
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Childhood Immunization Status* • *Breast Cancer Screening*	**Strengths Identified:** – 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 project population in relation to the aim statement for one project. – The organization selected project variables and performance measures that were clear indicators of performance for one project. – The organization used valid and reliable procedures to collect the project 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 Identified from EQRO CY 2023 Recommendations:** – The organization included lessons learned or opportunities for improvement based on the data analysis when the aim was not achieved. **Recommendations Identified:** – Clearly specify the time period for the project in the aim statement. – Ensure aim statements are answerable by including all required elements. – Clearly define the project population in terms of the identified project aim statement. – Ensure variables are adequate to answer the study question. – Analyze data according to the data analysis plan or explain any deviation from the plan when warranted. – Include an analysis of the baseline and repeat measures identified according to the project aim statement. – Conduct and include statistical analysis when results improve or decline in future project reports. – Ensure project results are compared across other entities, such as different organizations or sub-groups.

MercyCare Health Plans	
Programs Operated	**CY 2024 Enrollment by Program**
BC+	BC+: 12,251
Findings	
	– Ensure project findings are presented in an easily understood manner. – Assess and describe the effectiveness of each improvement strategy in future reports. – Continue to develop methodologically sound projects to demonstrate quantitative evidence of improvement. – Include statistical evidence that any observed improvement is the result of the interventions. – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care. – Report the baseline and repeat measurements according to the aim statement in future projects.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the BadgerCare Plus program: o Prenatal and Postpartum Care - Timeliness of Prenatal Care; and o Prenatal and Postpartum Care - Postpartum Care. **Progress Identified from EQRO CY 2023 Recommendations:** – Improved the BadgerCare Plus rate for Lead Screening in Children. **Recommendations Identified:** – The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program: o Childhood Immunization Status - Combo 3; o Immunizations for Adolescents - Combo 2; o Lead Screening in Children; o Child and Adolescent Well-Care Visits; o Asthma Medication Ratio (Total); o Hemoglobin A1c Control for Patients with Diabetes; o Controlling Blood Pressure; and o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths Identified:** – The organization demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to the Wisconsin Department of Health Services review for grievances and to the State Fair Hearing system for appeals, when decisions are adverse to the member. **Progress Identified from EQRO CY 2021 Recommendations:** – The organization distributed the informational flyer on member grievance and appeals rights to its gatekeepers, providers, subcontractors, and IPAs at the time of contracting. **Recommendations Identified:** – Develop and implement a process to document and provide feedback to members in response to their input on quality improvement.

MercyCare Health Plans	
Programs Operated	**CY 2024 Enrollment by Program**
BC+	BC+: 12,251
Findings	
	– Ensure the quality improvement workplan includes submission of the audited pay-for-performance results to the Wisconsin Department of Health Services, and the timeframe for submitting the results. – Ensure the quality improvement workplan includes submission of the annual Performance Improvement Project final reports to the Wisconsin Department of Health Services and to the External Quality Review Organization. – Update documentation to reference language and formatting requirements for grievance resolution notices. – Amend service denial notification policies and procedures to specify requirements to send a notice no later than the date of action when the member is in a facility and will be transferred or discharged in less than 10 days as a result of individual health and safety concerns, improvement of health, urgent medical needs, or the member has not resided in the nursing facility for 30 days. – Develop systems to ensure service denial policies and procedures are updated timely for contract requirements and changes.
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization fully met all Information System categories evaluated in the previous review. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

MHS Health Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 46,617 SSI: 6,084
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Asthma Management*	**Strengths Identified:** – 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 project population in relation to the aim statement for both projects.

MHS Health Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 46,617 SSI: 6,084
Findings	
	– The organization selected project variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the project data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the project data and interpret the results for one project. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. – The organization utilized methodology that was likely to demonstrate significant and sustained improvement for one project. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization detailed the inter-rater and intra-rater reliability process for organizational staff conducting medical record review. – The organization documented a continuous cycle of improvement used to test a selected improvement strategy. **Recommendations Identified:** – Establish a goal that is an improvement over the rate obtained during the previous measurement year. – Ensure the project's results and findings are presented in a concise and easily understood manner. – Demonstrate sustained improvement through repeated measurements over time for continuing projects. – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the BadgerCare Plus program: o Prenatal and Postpartum Care - Timeliness of Prenatal Care; o Hemoglobin A1c Control for Patients with Diabetes; and o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – The following rates were strengths for the Supplemental Security Income program: o Asthma Medication Ratio (Ages 19-64); and, o Hemoglobin A1c Control for Patients with Diabetes. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program: o Childhood Immunization Status - Combo 3; o Immunizations for Adolescents - Combo 2; o Lead Screening in Children;

MHS Health Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 46,617 SSI: 6,084
Findings	
	○ Child and Adolescent Well-Care Visits; ○ Prenatal and Postpartum Care - Postpartum Care; ○ Asthma Medication Ratio (Total); and ○ Controlling Blood Pressure. – The following rates demonstrated an opportunity for improvement for the Supplemental Security Income program: ○ Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); ○ Diabetes Screening for People with Schizophrenia or Bipolar; Disorder Who Are Using Antipsychotic Medications; ○ Breast Cancer Screening; and ○ Cervical Cancer Screening.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths Identified:** – The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members. – The organization demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to a Wisconsin Department of Health Services review for grievances and to the State Fair Hearing system for appeals, when decisions are adverse to the member. **Progress Identified from EQRO CY 2021 Recommendations:** – The organization included an evaluation of under and overutilization of services in quality management program. – The organization implemented a process to ensure written notifications of adverse benefit determinations are issued as required. – The organization ensured practices are compliant with requirements for an expedited review process for appeals. **Recommendations Identified:** – Focus efforts to assure written policies and procedures outline the requirements for when a grievance or appeal is submitted by an individual acting as the member's authorized representative. Requirements include: ○ Upon receipt of the grievance or appeal request, attempt to follow up with the member to confirm the desire to proceed. ○ If the member confirms the desire to proceed with the grievance or appeal, inform the member of the need to provide written consent for an individual to act as the member's authorized representative, or the grievance or appeal will be processed as a request from the member. ○ If the member does not wish to proceed, dismiss the grievance or appeal and send written notice. ○ If no contact is made with the member within 30 calendar days, dismiss the grievance or appeal and send written notice. – Ensure members are provided prompt oral and written notice of extensions of timeframes for resolution of appeals not at the request of the member.

MHS Health Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 46,617 SSI: 6,084
Findings	
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths Identified:** – No strengths were identified. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – Conduct member screens timely. – Complete care plans within the required timeframes. – Distribute care plans to all required team members. – Ensure members are contacted once every 12 months or more based on their stratification. – Provide timely follow-up for member needs. – Update the member care plan at least once every 12 months. – Update the member care plan for changing member needs. – Ensure members are re-stratified after experiencing a critical event. – Contact members within five business days of discharge from a hospital. – Ensure transitional care follow-up includes a review of hospital discharge information with the member within the required timeframe. – Ensure the Wisconsin Interdisciplinary Care Team meets with members face-to-face once per month.
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization demonstrated effective procedures for submitting measure-relevant information for data entry, including checking procedures for electronic transmissions to ensure accuracy. – The organization performed consistent oversight and validation of vendors to ensure vendors met expected performance standards. – The organization identified and corrected incorrect extraction of data fields and delays in recognizing and/or remediating the underlying issues. – The organization identified and corrected issues and delays related to improper identification of populations, utilization data extracts, and measure report set selection. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Molina HealthCare of Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 69,716 SSI: 5,152
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Diabetic Care*	**Strengths Identified:** – 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 project population in relation to the aim statement for both projects. – The organization selected project variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the project data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the project data and interpret the results for one project. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – Ensure the aim statement clearly specifies the improvement strategy. – Clearly define the population in the aim statement. – Identify the beginning and end date of the project in the aim statement. – Ensure the aim statement includes all required criteria. – Ensure the aim statement is measurable. – Include an analysis of the baseline and repeat measures identified according to the project aim statement. – Conduct statistical testing analysis for all aim statements in future project reports. – Ensure that selected improvement strategies utilized are evidence-based. – Develop methodologically sound projects to demonstrate quantitative evidence of improvement. – Focus efforts on improving results to gain quantitative evidence of improvement through repeated measurements each year of a continuing project. – Develop and implement improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the BadgerCare Plus program: ○ Prenatal and Postpartum Care - Timeliness of Prenatal Care; ○ Prenatal and Postpartum Care - Postpartum Care; ○ Hemoglobin A1c Control for Patients with Diabetes; and ○ Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total.

Molina HealthCare of Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 69,716 SSI: 5,152
Findings	

	– The following rate was a strength for the Supplemental Security Income program:
	  ○ Hemoglobin A1c Control for Patients with Diabetes.
	
	Progress Identified from EQRO CY 2023 Recommendations:
	– No progress was identified.
	
	Recommendations Identified:
	– The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program:
	  ○ Childhood Immunization Status - Combo 3;
	  ○ Immunizations for Adolescents - Combo 2;
	  ○ Lead Screening in Children;
	  ○ Child and Adolescent Well-Care Visits;
	  ○ Asthma Medication Ratio (Total); and
	  ○ Controlling Blood Pressure.
	– The following rates demonstrated an opportunity for improvement for the Supplemental Security Income program:
	  ○ Asthma Medication Ratio (Ages 19-64);
	  ○ Follow-Up After Hospitalization for Mental Illness - 30 Days (Total);
	  ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total);
	  ○ Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications;
	  ○ Breast Cancer Screening; and
	  ○ Cervical Cancer Screening.

Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths Identified:** – The organization demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to the Wisconsin Department of Health Services review for grievances and to the State's Fair Hearing system for appeals, when decisions are adverse to the member. **Progress Identified from EQRO CY 2021 Recommendations:** – No progress was identified. **Recommendations Identified:** – Develop and implement a process to document response from member input received by the quality committee, including the feedback provided to members in response to the input received. – Include submission of the audited pay-for-performance results to the Wisconsin Department of Health Services, and the timeframe for submitting the results in the Quality Improvement workplan. – Include the submission of the final performance improvement projects reports to the External Quality Review Organization, and the timeframe for submitting the reports in the Quality Improvement workplan.

Molina HealthCare of Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 69,716 SSI: 5,152
Findings	
	– Revise documentation to include the formal requirements to ensure written grievance resolution letters follow format and language guidelines. – Update documentation to ensure contracted providers do not take punitive action against anyone who requests an expedited resolution of an appeal or supports a member's appeal. – Develop a process that details the timing of sharing the *Ombudsman Brochure* and the *HMO and PIHP Member Grievances and Appeal Guide* to the organization's gatekeepers, providers, subcontractors, and independent practice associations. – Ensure providers and subcontractors have written procedures describing how members are informed of denied services, and have copies for review if requested by the Wisconsin Department of Health Services.
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths Identified:** – No strengths were identified. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization ensured member care plans were comprehensive. **Recommendations Identified:** – Ensure the screens are completed timely. – Develop comprehensive screens. – Complete timely care plans. – Distribute care plans to all required persons. – Contact members at least once every 12 months or more frequently based on stratification levels. – Address follow-up needs timely. – Ensure care plans are reviewed once every 12 months. – Update the care plans for changing member needs. – Re-stratify members after a critical event. – Contact members within five business days of discharge from a hospital. – Complete transitional care follow-up of hospital discharge within the required timeframe.
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization fully met all Information System categories evaluated in the previous review. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.

Molina HealthCare of Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 69,716 SSI: 5,152
Findings	
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

My Choice Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	My Choice Wisconsin was acquired by Molina HealthCare in CY 2023. No members are enrolled in this organization.
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Follow-Up After Hospitalization for Mental Illness*	**Strengths Identified:** – 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 project population in relation to the aim statement for both projects. – The organization selected project variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the project data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the project 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 utilized methodology that was likely to demonstrate significant and sustained improvement for one project. – The organization demonstrated significant improvement that may likely be the result of selected interventions for one project. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization ensured the aim statements were concise, – The organization reported the project results in a concise and easily understood manner. – The organization developed methodologically sound performance improvement projects to ensure results had quantitative evidence of improvement from the baseline rates that were sustained through repeated measurements. **Recommendations Identified:** – Implement improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the Supplemental Security Income program: ○ Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); and

<table>
<tr><th colspan="2">My Choice Wisconsin</th></tr>
<tr><th>Programs Operated</th><th>CY 2024 Enrollment by Program</th></tr>
<tr><td>BC+, SSI</td><td>My Choice Wisconsin was acquired by Molina HealthCare in CY 2023. No members are enrolled in this organization.</td></tr>
<tr><th colspan="2">Findings</th></tr>
<tr><td></td><td>

Hemoglobin A1c Control for Patients with Diabetes.

Progress Identified from EQRO CY 2023 Recommendations:

Improved BadgerCare Plus rates for:

Childhood Immunization Status - Combo 3;
Lead Screening in Children;
Prenatal and Postpartum Care - Timeliness of Prenatal Care; and
Prenatal and Postpartum Care - Postpartum Care.

Recommendations Identified:

The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program:

Childhood Immunization Status - Combo 3;
Immunizations for Adolescents - Combo 2;
Lead Screening in Children;
Child and Adolescent Well-Care Visits;
Prenatal and Postpartum Care - Timeliness of Prenatal Care;
Prenatal and Postpartum Care - Postpartum Care;
Asthma Medication Ratio (Total);
Hemoglobin A1c Control for Patients with Diabetes;
Controlling Blood Pressure; and
Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total.

The following rates demonstrated an opportunity for improvement for the Supplemental Security Income program:

Asthma Medication Ratio (Ages 19-64);
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications;
Breast Cancer Screening; and
Cervical Cancer Screening.

</td></tr>
<tr><td>Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review</td><td>The organization was acquired by Molina HealthCare in CY 2023.</td></tr>
<tr><td>Protocol 4: Network Adequacy Validation</td><td>The organization was acquired by Molina HealthCare in CY 2023.</td></tr>
<tr><td>Protocol 9: Conducting Focused Studies of Health Care Quality
SSI Care Management Review</td><td>The organization was acquired by Molina HealthCare in CY 2023.</td></tr>
</table>

My Choice Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	My Choice Wisconsin was acquired by Molina HealthCare in CY 2023. No members are enrolled in this organization.
Findings	
Appendix A: Information Systems Capabilities Assessment	The organization was acquired by Molina HealthCare in CY 2023.
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Network Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 42,928 SSI: 3,919
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Hypertension and Diabetes*	**Strengths Identified:** – 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 project population in relation to the aim statement for both projects. – The organization selected project variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the project data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the project data and interpret the results for one project. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. – The organization utilized methodology that was likely to demonstrate significant and sustained improvement for one project. – The organization demonstrated significant improvement that may likely be the result of selected interventions one project. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization detailed the inter-rater and intra-rater reliability process for organizational staff conducting medical record review. – The organization documented a continuous cycle of improvement used to test a selected improvement strategy. – The organization designed a methodologically sound performance improvement project to ensure project results demonstrated an improvement from the baseline rate identified in the project's aim statement.

Network Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 42,928 SSI: 3,919
Findings	
	Recommendations Identified: – Establish a goal that is an improvement over the rate obtained during the previous measurement year. – Ensure the project's results and findings are presented in a concise and easily understood manner. – Ensure sustained improvement is demonstrated through repeated measurements over time for continuing projects. – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the BadgerCare Plus program: o Prenatal and Postpartum Care - Timeliness of Prenatal Care; o Prenatal and Postpartum Care - Postpartum Care; and o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – The following rates were strengths for the Supplemental Security Income program: o Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); and, o Hemoglobin A1c Control for Patients with Diabetes. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program: o Childhood Immunization Status - Combo 3; o Immunizations for Adolescents - Combo 2; o Lead Screening in Children; o Child and Adolescent Well-Care Visits; o Asthma Medication Ratio (Total); o Hemoglobin A1c Control for Patients with Diabetes; and o Controlling Blood Pressure. – The following rates demonstrated an opportunity for improvement for the Supplemental Security Income program: o Asthma Medication Ratio (Ages 19-64); o Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); o Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; o Breast Cancer Screening; and o Cervical Cancer Screening.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	**Strengths Identified:** – The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members.

Network Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 42,928 SSI: 3,919
Findings	
Accreditation Desk Review	– The organization demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to the Wisconsin Department of Health Services review for grievances and to the State Fair Hearing system for appeals, when decisions are adverse to the member. **Progress Identified from EQRO CY 2021 Recommendations:** – The organization included an evaluation of under and overutilization of services in quality management program. – The organization ensured requirements for an expedited review process for appeals. – The organization updated internal documentation to include: o Grievance and appeal system requirements specific to the State of Wisconsin, including the requirement that the organization may only have one level of appeal for members; o The ability of members to request an extension to the appeal resolution timeframe; o The provision of oral notification to the member of the extension to the appeal resolution timeframe; o The timeframe for issuance of written notification to the member when the appeal resolution timeframe is extended; o The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner if possible; and o The timeframe by which the organization provides information about the grievance and appeal system to all providers and subcontractors, including the *Ombudsman Brochure*. – The organization developed a process related to the issuance of written notification of adverse benefit determinations when claims are denied. **Recommendations Identified:** – Focus efforts to assure written policies and procedures outline the requirements for when a grievance or appeal is submitted by an individual acting as the member's authorized representative. Requirements include: o Upon receipt of the grievance or appeal request, attempt to follow up with the member to confirm the desire to proceed. o If the member confirms the desire to proceed with the grievance or appeal, inform the member of the need to provide written consent for an individual to act as the member's authorized representative, or the grievance or appeal will be processed as a request from the member. o If the member does not wish to proceed, dismiss the grievance or appeal and send written notice. o If no contact is made with the member within 30 calendar days, dismiss the grievance or appeal and send written notice. – Ensure members are provided prompt oral and written notice of extensions of timeframes for resolution of appeals not at the request of the member.

Network Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 42,928 SSI: 3,919
Findings	
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths Identified:** – The organization demonstrated strengths related to the Wisconsin Interdisciplinary Care Team practices. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – Conduct member screens timely. – Complete care plans within the required timeframes. – Ensure members are contacted once every 12 months or more based on their stratification. – Provide timely follow-up for member needs. – Review the member care plan at least once every 12 months. – Update the member care plan for changing member needs. – Ensure members are re-stratified after experiencing a critical event. – Contact members within five business days of discharge from a hospital. – Ensure transitional care follow-up includes a review of hospital discharge information within the required timeframe.
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization demonstrated effective procedures for submitting measure-relevant information for data entry, including checking procedures for electronic transmissions to ensure accuracy. – The organization performed consistent oversight and validation of vendors to ensure vendors met expected performance standards. – The organization identified and corrected incorrect extraction of data fields and delays in recognizing and/or remediating the underlying issues. – The organization identified and corrected issues and delays related to improper identification of populations, utilization data extracts, and measure report set selection. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Quartz Health Solutions, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 41,604 SSI: 477
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Diabetic Care*	**Strengths Identified:** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization clearly identified the project population in relation to the aim statement for one project. – The organization selected project variables and performance measures that were clear indicators of performance for one project. – The organization used valid and reliable procedures to collect the project data and inform its measurements for one project. – The organization used appropriate techniques to analyze the project data and interpret the results for one project. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization ensured the aim statement was concise. – The organization specified the frequency of data collection in the project design. – The organization included a data collection plan that linked to the data analysis plan. – The organization included a baseline measure to be able to analyze baseline and repeat measurements of project outcomes. – The organization included lessons learned in the analysis of the data for projects that had less than optimal performance. – The organization demonstrated improvement strategies were evidence-based. – The organization completed and documented all stages of a rapid-cycle Plan-Do-Study-Act approach in the reports. **Recommendations Identified:** – Ensure the aim statement clearly specifies the population for the project. – Identify the population within the aim statement to guarantee the aim statement is answerable. – Identify a numeric measurement goal of improvement to guarantee the aim statement is measurable. – Ensure the data collection approach captures all enrollees to whom the project question applies when the entire population is included. – Update the aim statement and other relevant standard narrative when a new measure is required to conduct the project. – Include a strategy to ensure inter-rater reliability for manual data entry. – Ensure an inter-rater reliability process is in place for medical record review. – Document guidelines for obtaining and recording data from medical record review. – Generate a baseline rate specific to the organization to ensure statistical testing can be conducted to determine the differences between initial and repeat measures.

Quartz Health Solutions, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 41,604 SSI: 477
Findings	
	– Account for factors that may influence the comparability of initial and repeat measures. – Compare project results across multiple entities or subgroups. – Present project findings in a concise and easily understood manner. – Implement a strategy designed to account or adjust for any major confounding variables. – Ensure the same methodology is used for baseline and repeat measurements. – Continue to build methodologically sound performance improvement projects to ensure quantitative improvement is demonstrated from baseline to repeat rates. – Ensure project improvement is the result of the intervention. – Include statistical evidence that any observed improvement is the result of the intervention. – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care. – Generate a baseline specific to the organization to ensure comparability between baseline and repeat measurements.
Protocol 2: Validation of Performance Measures **Performance measures for the Supplemental Security Income program had denominators less than 30; therefore, not reportable.*	**Strengths Identified:** – The following rates were strengths for the BadgerCare Plus program: o Prenatal and Postpartum Care - Postpartum Care; and o Hemoglobin A1c Control for Patients with Diabetes. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program: o Childhood Immunization Status - Combo 3; o Immunizations for Adolescents - Combo 2; o Lead Screening in Children; o Child and Adolescent Well-Care Visits; o Prenatal and Postpartum Care - Timeliness of Prenatal Care; o Asthma Medication Ratio (Total); o Controlling Blood Pressure; and o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths Identified:** – No strengths were identified. **Progress Identified from EQRO CY 2021 Recommendations:** – No progress was identified. **Recommendations Identified:**

Quartz Health Solutions, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 41,604 SSI: 477
Findings	
	– Develop and implement a process to ensure the organization monitors and identifies patterns of over and underutilization of services in the Quality Management program. – Develop and implement a process to ensure that any part of the Utilization Management program delegated to a third party, meets contract requirements. – Include submission of the audited pay-for-performance results to Wisconsin Department of Health Services, and the timeframe for submitting the results in the Quality Improvement workplan. – Include the submission of the audited project results to the External Quality Review Organization. – Update documentation to include the requirement to mail a notice of termination, suspension, or reduction of previously authorized Medicaid covered services at least 10 days before the date of action. – Amend documentation to include all occurrences in which the organization may send a notice of adverse benefit determination. – Revise documentation to include when the organization may shorten the period of advance notice to five days before the action. – Revise processes to ensure a final written decision is sent for grievances resolved during the initial phone call to the organization. – Update processes to include when a grievance or appeal is submitted by an individual purporting to be the member's authorized representative and the organization does not have the documented consent for the individual to act as the member's representative on file. – Revise documentation to ensure members are allotted 90 calendar days, including the timeframe to receive the organization's notice to uphold the adverse benefit determination, to request a State Fair Hearing. – Amend documentation to identify the materials that are required to be provided upon request for information regarding a State Fair Hearing. – Update documents to ensure distribution of member grievance and appeal rights and corresponding documents to providers and subcontractors. – Revise documents to ensure copies of provider's and subcontractor's written procedures describing how services are denied are available for review upon request by Wisconsin Department of Health Services. – Amend appeal policies and procedures to include the requirements for when the member's benefits must continue. – Develop and implement an appeal process to indicate benefits must continue until one of the contract identified situations occur.
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths Identified:** – No strengths were identified. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified.

Quartz Health Solutions, Inc.	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 41,604 SSI: 477
Findings	
	Recommendations Identified: – Conduct timely screens. – Complete comprehensive screens. – Conduct timely care plans. – Complete comprehensive care plans. – Share care plans with all required individuals. – Ensure member care plan agreement prior to implementation. – Contact members based on the assigned stratification level. – Update care plans at least once every 12 months. – Contact members within five business days of hospitalization discharge. – Ensure transition care follow-up occurs when contacting members after hospitalization discharge.
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization fully met all Information System categories evaluated in the previous review. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Security Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 62,553 SSI: 651
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Diabetic Care*	**Strengths Identified:** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for one project. – The organization established a clear, concise, measurable, and answerable aim statement for one project. – The organization clearly identified the project population in relation to the aim statement for both projects. – The organization selected project variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the project data and inform its measurements for one project. – The organization used appropriate techniques to analyze the project data and interpret the results for both projects.

Security Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 62,553 SSI: 651
Findings	
	– The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization developed measurable aim statements by including a baseline measure for each aim. – The organization ensured the data collection plan was linked to the data analysis plan. – The organization ensured data analysis was conducted in accordance with the data analysis plan. – The organization ensured analysis included baseline and repeat measures for each aim statement. – The organization included evidence of statistical analysis to assess differences between initial and repeat measures. – The organization ensured final project results were concise and easily understood. – The organization ensured improvement strategies were evidence based. – The organization designed strategies that accounted or adjusted for barriers that may have impacted project outcomes. – The organization incorporated cultural and linguistic considerations in improvement strategies. – The organization developed a plan to address variables encountered during the project. – The organization assessed the extent to which the improvement strategies were successful. – The organization ensured the same methodology was used for baseline and repeat measures. **Recommendations Identified:** – Conduct a member needs analysis to prioritize and select a topic as an area for improvement for future projects. – Include the project's improvement strategy in future aim statements. – Clearly specify the time period for the project in the aim statement. – Ensure the aim statement is concise. – Ensure aim statements are answerable by including all required elements. – Detail the staff responsible for medical record data abstraction and their relevant qualifications. – Describe the inter-rater and intra-rater reliability process for staff conducting medical record chart review. – Ensure continuous cycles of improvement are detailed in the project report. – Assess and describe the effectiveness of each improvement strategy in future reports. – Continue to develop methodologically sound projects to demonstrate quantitative evidence of improvement.

Security Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 62,553 SSI: 651
Findings	
	– Focus efforts on improving results of repeat measurements each year of a continuing project. – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the BadgerCare Plus program: o Childhood Immunization Status - Combo 3; o Asthma Medication Ratio (Total); and o Hemoglobin A1c Control for Patients with Diabetes. – The following rates were strengths for the Supplemental Security Income program: o Hemoglobin A1c Control for Patients with Diabetes; and o Breast Cancer Screening. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program: o Immunizations for Adolescents - Combo 2; o Lead Screening in Children; o Child and Adolescent Well-Care Visits; o Prenatal and Postpartum Care - Timeliness of Prenatal Care; o Prenatal and Postpartum Care - Postpartum Care; o Controlling Blood Pressure; and o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – The following rate demonstrated an opportunity for improvement for the Supplemental Security Income program: o Cervical Cancer Screening.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths Identified:** – The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members. – The organization demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to a Wisconsin Department of Health Services review for grievances and to the State Fair Hearing system for appeals, when decisions are adverse to the member. **Progress Identified from EQRO CY 2021 Recommendations:** – The organization ensured processes included a mechanism to detect both under and overutilization of services into the quality improvement program. – The organization's practices demonstrated compliance with issuing notices of adverse benefit determination when previously authorized services are reduced, terminated, or suspended.

Security Health Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 62,553 SSI: 651
Findings	
	– The organization updated procedures to include the requirement that a member may be held liable for the cost of continuing benefits during the State Fair Hearing process. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths Identified:** – No strengths were identified. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization ensured care plans were comprehensive. – The organization improved efforts to contact members at their assigned stratification level. **Recommendations Identified:** – Conduct member screens timely. – Complete care plans within the required timeframes. – Ensure members are contacted once every 12 months or more based on their stratification. – Provide timely follow-up for member needs. – Update the member care plan at least once every 12 months. – Update the member care plan for changing member needs. – Ensure members are re-stratified after experiencing a critical event. – Contact members within five business days of discharge from a hospital. – Ensure transitional care follow-up includes a review of hospital discharge information within the required timeframe.
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization fully met all Information System categories evaluated in the previous review. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

United Healthcare Community Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 202,412 SSI: 17,478
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Prenatal and Postpartum Care* • *Controlling Blood Pressure*	**Strengths Identified:** – 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 project population in relation to the aim statement for both projects. – The organization selected project variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the project data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the project 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 utilized methodology that was likely to demonstrate significant and sustained improvement for one project. – The organization demonstrated significant improvement that may likely be the result of selected interventions for one project. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – Continue to build methodologically sound performance improvement projects to demonstrate improvement from baseline to remeasurement. – Ensure sustained improvement is demonstrated through repeated measurements over time for continuing projects.
Protocol 2: Validation of Performance Measures	**Strengths Identified:** – The following rates were strengths for the BadgerCare Plus program: o Lead Screening in Children; o Prenatal and Postpartum Care - Timeliness of Prenatal Care; and o Hemoglobin A1c Control for Patients with Diabetes. – The following rate was a strength for the Supplemental Security Income program: o Hemoglobin A1c Control for Patients with Diabetes. **Progress Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – The following rates demonstrated an opportunity for improvement for the BadgerCare Plus program: o Childhood Immunization Status - Combo 3; o Immunizations for Adolescents - Combo 2; o Child and Adolescent Well-Care Visits;

United Healthcare Community Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 202,412 SSI: 17,478
Findings	
	○ Prenatal and Postpartum Care - Postpartum Care; ○ Asthma Medication Ratio (Total); ○ Controlling Blood Pressure; and ○ Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – The following rates demonstrated an opportunity for improvement for the Supplemental Security Income program: ○ Asthma Medication Ratio (Ages 19-64); ○ Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); ○ Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; ○ Breast Cancer Screening; and ○ Cervical Cancer Screening.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review *Accreditation Desk Review*	**Strengths Identified:** – The organization has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members. – The organization's Member and Community Advisory Board is made up of both health plan members and community leaders from diverse organizations. The Member and Community Advisory Board obtains member feedback, ideas, and barriers and incorporates the feedback into suggested changes for quality improvement. **Progress Identified from EQRO CY 2021 Recommendations:** – No progress was identified. **Recommendations Identified:** – Revise documents to ensure a final written decision is sent to members for grievances resolved during the initial phone call to the organization. – Update processes to include the contract requirements if a grievance or appeal is submitted by an individual purporting to be the member's authorized representative and the organization does not have the documented consent for the individual to act as the member's representative on file. – Amend documentation to include format requirements to ensure written grievance resolution letters follow requirements. – Ensure documentation indicates the organization must issue a separate written notice of appeal resolution for each adverse benefit determination appealed by a member, including those in favor and not in favor of the member. – Revise documents to include that contracted providers ensure no punitive action is taken against anyone who requests an expedited resolution of an appeal or supports a member's appeal. – Ensure member grievance and appeal rights and corresponding documents are distributed to providers and subcontractors.

United Healthcare Community Plan	
Programs Operated	**CY 2024 Enrollment by Program**
BC+, SSI	BC+: 202,412 SSI: 17,478
Findings	
	– Ensure providers and subcontractors have written procedures describing how members are informed of denied services, and have copies for review if requested by Wisconsin Department of Health Services. – Amend appeal policies and procedures to include all the requirements for when the member's benefits must continue.
Protocol 4: Network Adequacy Validation	The protocol will be implemented in CY 2025.
Protocol 9: Conducting Focused Studies of Health Care Quality *SSI Care Management Review*	**Strengths Identified:** – No strengths were identified. **Progress Identified:** – The organization ensured care plans were updated for changing member needs. **Progress Identified from EQRO CY 2023 Recommendations:** – Conduct timely screens. – Complete care plans within the required timeframes. – Share the care plans with all required persons. – Contact the member based on the member's stratification level. – Provide timely follow-up of identified member needs. – Update the member care plan at least once every 12 months. – Update the member care plan for changing member needs. – Ensure the member is re-stratified after a critical event. – Ensure timely transition planning following a hospitalization. – Complete timely transition care follow-up of hospital discharge information.
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified:** – The organization fully met all Information System categories evaluated through the organization's annual HEDIS® audit. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization fully met all Information System categories evaluated in the previous review. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.
Record Review *Obstetrics Medical Home Record Review*	The results of the Obstetrics Medical Home review are reported separately.

Children Come First	
Programs Operated	**CY 2024 Enrollment by Program**
Children's Mental Health	The Children Come First program ceased operations in CY 2023. No members are enrolled in this program.
Findings	
Protocol 1: Validation of Performance Improvement Projects • *Program Transition*	**Strengths Identified:** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for the project. – The organization established a clear, concise, measurable and answerable aim statement for the project. – The organization clearly identified the project population in relation to the aim statement for the project. **Progress Identified from EQRO CY 2023 Recommendations:** – The organization provided an aim statement that comprised all required elements including the project's improvement strategy, measurement period, baseline rate, and goal for improvement. – The organization designed performance measures that monitored, tracked, and compared performance over the course of the project. – The organization analyzed the impact of the project's interventions. – The organization conducted a project that demonstrated improvement from baseline to repeat measurement. **Recommendations Identified:** – Implement an inter-rater reliability process for manual data entry. – Ensure electronic health record data is validated for accuracy and completeness as well as comparability across systems. – Conduct statistical testing between baseline and repeat measures. – Compare project results to at least one other entity or subgroup. – Ensure the selected improvement strategies are evidenced-based. – Include a Plan-Do-Study-Act approach to evaluate improvement strategies. – Ensure statistical testing is conducted between baseline and repeat measures to determine if the observed improvement is the result of the intervention. – Develop a performance improvement project that produces a statistically significant improvement between baseline and repeat measures.
Protocol 2: Validation of Performance Measures	The organization ceased program operations in CY 2023.
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	The organization ceased program operations in CY 2023.
Protocol 4: Network Adequacy Validation	The organization ceased program operations in CY 2023.
Appendix A: Information Systems Capabilities Assessment	The organization ceased program operations in CY 2023.

Wraparound Milwaukee	
Programs Operated	**CY 2024 Enrollment by Program**
Children's Mental Health	The Wraparound Milwaukee program ceased operations in CY 2024. No members are enrolled in this program.
Findings	
Protocol 1: Validation of Performance Improvement Projects • *AODA Services* • *Literacy*	**Strengths Identified:** – 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 project population in relation to the aim statement for both projects. – The organization selected project variables and performance measures that were clear indicators of performance for one project. – The organization used valid and reliable procedures to collect the project 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 Identified from EQRO CY 2023 Recommendations:** – No progress was identified. **Recommendations Identified:** – Clearly specify the beginning and end date of the time period for the project in each aim statement. – Ensure each aim statement is answerable by including accurate criteria for the aim. – Develop measurable aim statements by including a baseline measure for each aim. – Ensure the variables are adequate to answer the project question. – Ensure the project includes a strategy for inter-rater reliability for manual data collection. – Ensure analysis includes baseline and repeat measures for each aim statement. – Assess statistical significance between the initial and repeat measures with an established baseline. – Ensure final project results are concise and easily understood. – Ensure the same methodology is used for baseline and repeat measurements. – Develop methodologically sound projects to demonstrate quantitative evidence of improvement. – Develop and implement improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care.
Protocol 2: Validation of Performance Measures	The organization ceased program operations in CY 2024. No performance measures were established for Wraparound Milwaukee.

Wraparound Milwaukee	
Programs Operated	**CY 2024 Enrollment by Program**
Children's Mental Health	The Wraparound Milwaukee program ceased operations in CY 2024. No members are enrolled in this program.
Findings	
Protocol 3: Compliance with Managed Care Regulations, Compliance with Standards Review	The organization's last Compliance with Standards Review was conducted in CY 2021.The organization ceased program operations in CY 2024.
Protocol 4: Network Adequacy Validation	The organization ceased program operations in CY 2024.
Protocol 9: Conducting Focused Studies of Health Care Quality *Care Management Review*	The organization ceased program operations in CY 2024.
Appendix A: Information Systems Capabilities Assessment	The organization's last Information Systems Capabilities Assessment was conducted in CY 2021.The organization ceased program operations in CY 2024.

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

Children's Hospital of Wisconsin	
Programs Operated	**CY 2024 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
Record Review	**Strengths Identified:** – Program eligibility requirements were a strength for the organization. – The organization demonstrated strengths related to assessment processes. – The organization demonstrated strengths related to ongoing monitoring and service coordination. – The organization had strong practices in place for member hospitalization coordination and follow-up. **Progress Identified from EQRO CY 2023 Recommendations:** – Following the CY 2023 review, revisions were made at the request of Wisconsin Department of Health Services. Ratings from the previous review are not comparable; therefore, progress cannot be identified. **Recommendations Identified:** – Ensure that assessments are completed timely. – Place priority on updating the care plan at least once every six months. – Ensure care plan goals include actions for each goal and timeframes for initiating/completing each action.

Marshfield Children's Hospital	
Programs Operated	**CY 2024 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
Record Review	**Strengths Identified:** – Program eligibility requirements were a strength for the organization. – The organization demonstrated strengths related to assessment processes. – The organization had strong practices in place for member care planning. – The organization demonstrated strengths related to ongoing monitoring and service coordination. – The organization had strong practices in place for member hospitalization coordination and follow-up. **Progress Identified from EQRO CY 2023 Recommendations:** – Following the CY 2023 review, revisions were made at the request of Wisconsin Department of Health Services. Ratings from the previous review are not comparable; therefore, progress cannot be identified. **Recommendations Identified:** – The organization fully met all requirements. No recommendations were identified.

UW Health-American Family Children's Hospital	
Programs Operated	**CY 2024 Enrollment by Program**
Children with Medical Complexity	Not publicly reported
Findings	
Record Review	**Strengths Identified:** – The organization ensured assessments were comprehensive and completed timely. – The organization demonstrated strengths related to ongoing monitoring and service coordination. – The organization had strong practices in place for coordination and follow-up for member hospitalizations. **Progress Identified from EQRO CY 2023 Recommendations:** – Following the CY 2023 review, revisions were made at the request of Wisconsin Department of Health Services. Ratings from the previous review are not comparable; therefore, progress cannot be identified. **Recommendations Identified:** – Place priority on updating the care plan at least once every six months. – Ensure care plan goals include actions and timeframes for initiating and completing the actions. – Conduct timely follow-up after hospital discharge.

Protocol 1: Validation of Performance Improvement Projects

The Validation of Performance Improvement Projects (PIPs) is a mandatory External Quality Review (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.

The Department of Health Services (DHS) contractually requires organizations operating BadgerCare Plus (BC+), Supplemental Security Income (SSI), Foster Care Medical Home (FCMH), Wraparound Milwaukee (WM), and Children Come First (CCF) to annually make active progress on clinical and non-clinical PIPs relevant to healthcare needs and outcomes. Managed Care Organizations (MCOs) operating more than one of these programs may fulfill this PIP requirement by conducting one or both of the required PIPs with members from any or all programs. If the MCO chooses to combine programs in a single PIP, the baseline and outcome data must be separated by program enrollment.

The study methodology is assessed through the following steps:

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

MCOs and Prepaid Inpatient Health Plans (PIHPs) must seek DHS approval prior to beginning each project. For projects conducted during 2023, organizations submitted proposals to DHS in December 2022. DHS directed MCOs and PIHPs to submit final reports by July 1, 2024. MetaStar validated clinical and non-clinical PIPs for the organizations, for a total of 33 PIPs for the following organizations:

Organizations	Program(s)
Anthem Blue Cross and Blue Shield Health Plan (Anthem)	BC+ SSI

Organizations	Program(s)
Chorus Community Health Plan, Inc. (CCHP)	BC+ FCMH
Dean Health Plan, Inc. (DHP)	BC+
Group Health Cooperative of Eau Claire (GHC-EC)	BC+ SSI
Group Health Cooperative of South-Central Wisconsin (GHC-SCW)	BC+
Independent Care Health Plan (*i*Care)	BC+ SSI
MercyCare Health Plans (MCHP)	BC+
MHS Health Wisconsin (MHS)	BC+ SSI
Molina HealthCare of Wisconsin (MHWI)	BC+ SSI
My Choice Wisconsin, Inc. (MCW)	BC+ SSI
Network Health Plan (NHP)	BC+ SSI
Quartz Health Solutions, Inc. (Quartz)	BC+ SSI
Security Health Plan of Wisconsin, Inc. (SHP)	BC+ SSI
United Healthcare Community Plan (UHC)	BC+ SSI
Children Come First (CCF)	Children with mental health needs
Wraparound Milwaukee (WM)	Children with mental health needs

Overall PIP Results

Compliance with PIP requirements is expressed through validation ratings for the project's methodology and evidence of significant improvement. The methodology rating is based on the percentage of applicable scoring elements met for each standard. The significant improvement rating is determined through the use of a statistical test using the project's baseline and repeat measurement for the aim statement. If there are multiple aim statements, testing is completed on each aim and the lowest rating achieved is the significant improvement rating for the project. The validation ratings identified in the tables below reflect the EQRO's confidence in the PIP's methods and findings. See the Appendix for more information about the scoring methodology.

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

Significant Improvement Rating	
Validation Results	**Confidence Level**
High Confidence	90.0% - 100.0%
Moderate Confidence	80.0% - 89.9%
Low Confidence	70.0% - 79.9%
No Confidence	<70.0%

The validation results from the PIPs conducted by each MCO and PIHP are summarized in the table below.

Two validation ratings are displayed:

1. Methodology Rating – The level of confidence that the PIP adhered to acceptable methodology for all phases of the design, data collection, data analysis, and interpretation of PIP results.
2. Significant Improvement Rating – The level of confidence that the PIP produced evidence of significant improvement.

CY 2024 PIP Results					
MCO/ PIHP	**Program(s)**	**Topic**	**Population**	**Methodology Rating**	**Significant Improvement Rating**
Anthem	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	Low Confidence
Anthem	SSI	Follow-Up After High-Intensity Care for Substance Use Disorder	Children and Adults	High Confidence	Moderate Confidence
CCHP	BC+	Childhood Immunization Status	Children	High Confidence	No Confidence
CCHP	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	Low Confidence
CCHP	FCMH	Mental Health Evaluations	Children	High Confidence	No Confidence
CCHP	FCMH	Care Transitions	Children	No Confidence	No Confidence

CY 2024 PIP Results					
MCO/ PIHP	**Program(s)**	**Topic**	**Population**	**Methodology Rating**	**Significant Improvement Rating**
DHP	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	Moderate Confidence
DHP	BC+	Childhood Immunization Status	Children	High Confidence	Low Confidence
GHC-EC	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	Moderate Confidence
GHC-EC	SSI	Follow-Up After Hospitalization for Mental Illness	Adults	High Confidence	No Confidence
GHC-SCW	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	Low Confidence
GHC-SCW	SSI	Well-Child Visits	Children	High Confidence	Low Confidence
*i*Care	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	Low Confidence
*i*Care	SSI	Controlling Blood Pressure	Adults	Moderate Confidence	No Confidence
MCHP	BC+	Childhood Immunization Status	Children	Moderate Confidence	No Confidence
MCHP	BC+	Breast Cancer Screening	Adults	Low Confidence	No Confidence
MHS	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	Low Confidence
MHS	SSI	Asthma Management	Adults	High Confidence	Low Confidence
MHWI	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	Moderate Confidence
MHWI	SSI	Diabetic Care	Adults	Moderate Confidence	Low Confidence
MCW	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	Moderate Confidence
MCW	SSI	Follow-Up After Hospitalization	Adults	High Confidence	No Confidence

CY 2024 PIP Results					
MCO/ PIHP	**Program(s)**	**Topic**	**Population**	**Methodology Rating**	**Significant Improvement Rating**
		for Mental Illness			
NHP	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	Low Confidence
NHP	SSI	Hypertension and Diabetes	Adults	High Confidence	High Confidence
Quartz	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	No Confidence
Quartz	BC+	Diabetic Care	Adults	No Confidence	No Confidence
SHP	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	No Confidence
SHP	BC+	Diabetic Care	Adults	Low Confidence	No Confidence
UHC	BC+	Prenatal and Postpartum Care	Children and Adults	High Confidence	No Confidence
UHC	SSI	Controlling Blood Pressure	Adults	High Confidence	High Confidence
CCF	Children with mental health needs	Program Transition	Children	Moderate Confidence	Low Confidence
WM	Children with mental health needs	AODA Services	Children	Moderate Confidence	Low Confidence
WM	Children with mental health needs	Literacy	Children	Moderate Confidence	No Confidence

Following are the results of MetaStar's evaluation of the PIPs conducted by the MCOs and PIHPs in 2023.

Managed Care Organizations

The validation ratings for each MCO PIP project are identified below. The methodology section includes a table listing each standard that was evaluated for the PIP methodology. The table indicates the total number of scoring elements for all MCO PIP projects and the percentage of

scoring elements met in all MCO projects for each standard, which determined the methodology rating. Not all scoring elements apply to every project, which makes the total applicable elements for each project different. Scoring elements that are not applicable are identified as 'N/A.' The significant improvement section details the outcome for the aim(s) of each project.

Methodology

MetaStar's confidence that the MCO PIPs adhered to acceptable methodology for all phases was high.

CY 2024 (MY 2023) Methodology Rating – Managed Care Organizations			
Standards	**Scoring Elements**	**Percentage**	**Methodology Rating**
Standard 1: PIP Topic	114/115	99.1%	High Confidence
Standard 2: PIP Aim Statement	147/168	87.5%	Moderate Confidence
Standard 3: PIP Population	53/56	94.6%	High Confidence
Standard 4: Sampling Method*	N/A	N/A	N/A
Standard 5: PIP Variables and Performance Measures	179/183	97.8%	High Confidence
Standard 6: Data Collection Procedures	310/314	98.7%	High Confidence
Standard 7: Data Analysis and Interpretation of PIP Results	189/212	89.2%	Moderate Confidence
Standard 8: Improvement Strategies	153/168	91.1%	High Confidence
Standard 9: Significant and Sustained Improvement	74/100	74.0%	Low Confidence
Methodology Rating	**1,219/1,316**	**92.6%**	**High Confidence**

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

Observation and Analysis: Standard 1. PIP Topic

The MCOs 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 evaluated each PIP on five possible scoring elements. Collectively, the MCOs satisfied requirements for 114 out of 115 scoring elements, for a score of 99.1 percent.

All MCO PIP topics included an analysis of the topic selection and the importance of the topic to members. All but one PIP topic was selected through a comprehensive analysis of MCO enrollee needs, care, and services. Topics addressed priority areas and included enrollee and provider input when applicable.

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 evaluated each PIP on six possible scoring elements. Collectively, the MCOs satisfied requirements for 147 out of 168 scoring elements, for a score of 87.5 percent.

Scoring element 2.1 evaluated if the aim statements clearly specify the improvement strategy. Improvement strategies were not specified in the aim statements for one project conducted by MHWI, one project conducted by SHP, and both projects conducted by CCHP.

Scoring element 2.3 evaluated the time period for the PIP as part of the aim statement. One of two aim statements for a project conducted by MHWI did not include a time period for the project. In addition, MCHP and SHP did not include a start date in the aim statement for one of their projects.

Scoring element 2.5 evaluated if the aim statements were answerable by ensuring all needed components were part of the aim statement. Projects conducted by CCHP, MCHP, MHWI, Quartz, and SHP did not include all required components, and as a result, the aim statements for six projects were not answerable.

Scoring element 2.6 evaluated if the PIP aim statement was measurable. Anthem, MHS, and NHP included a goal for measurement year 2023 which was lower than the rate the organization attained in measurement year 2022. One of the MHWI aim statements did not include a baseline rate in the aim statement, and Quartz included a range for the project's goal versus a measurable rate for the project.

The table below identifies the aim statements for each PIP topic. The aim statements in the table are copied from the PIP reports submitted by the organizations. No adjustments or edits were made by MetaStar.

MCO	Topic	Aim Statement
Anthem	Prenatal and Postpartum Care	'Anthem will improve post-partum care Hybrid rates for Milwaukee County African American BadgerCare Plus members from 65.52% in MY2021 to 67.52% in MY2023, by implementing interventions that focus on transportation access, expanded doula services, access to community resources and education by 12/31/2023.'
Anthem	Follow-Up After High-Intensity Care for Substance Use Disorder	'To increase the HEDIS 30-day Follow-Up after High-Intensity Care for Substance Use (FUI) rates among SSI Black/African American members living in Milwaukee County from the current rates as of 25% MY2021 to at least the NCQA Quality Compass 25th percentile of 37.84% by MY2023 using targeted case management with medication assistance provider education, enhance Social Determinants of Health (SDOH) management, and increased utilization of member value-added benefits.'
CCHP	Prenatal and Postpartum Care	Aim A: 'Through implementing CCHP developed interventions that focus on the BadgerCare Plus female members with live birth deliveries between October 8 of 2022 and October 7, 2023, as a population, CCHP will improve overall post-partum care rates for Wisconsin BadgerCare Plus members from 77.32% in MY2021 to 83.39% in MY2023. This goal is based on a formula which calculates statistical significance.'
CCHP	Prenatal and Postpartum Care	Aim B: 'Through implementing CCHP developed interventions that focus on the BadgerCare Plus female members with live birth deliveries between October 8 of 2022 and October 7, 2023, CCHP will target the African American population as an underrepresented population and will improve their rate of post-partum care from 72.99% to 81.75% for MY 2023. This goal is based on a formula which calculates statistical significance.'
CCHP	Childhood Immunization Status	Aim A: 'Will the interventions implemented by CCHP increase the rate of routine early childhood immunizations for CCHP Medicaid members within the first 2 years of life, as measured by an increase in the WIR 24-Month Benchmark result from 59.14% to 61.14% during MY2023?'
CCHP	Childhood Immunization Status	Aim B: 'Will the interventions implemented by CCHP increase the rate of routine early childhood immunizations for CCHP Medicaid members within the first 2 years of life, as measured by an increase in the HEDIS CIS Combo #3 measure result from 57.91% to 59.91% during MY2023?'
CCHP	Childhood Immunization Status	Aim C: 'Will the interventions implemented by CCHP increase the rate of routine early childhood immunizations for CCHP Medicaid members within the first 2 years of life who self-report their race as Black/African American, as measured by an increase in the WIR 24-Month Benchmark result from 52.28% to 55.28% in MY2023?'

MCO	Topic	Aim Statement
CCHP	Childhood Immunization Status	Aim D: 'Will the interventions implemented by CCHP increase the rate of routine early childhood immunizations for CCHP Medicaid members within the first 2 years of life who self-report their race as Black/African American, as measured by an increase in the HEDIS CIS Combo #3 measure result from 48.01% to 52.01% in MY2023?'
CCHP	Childhood Immunization Status	Aim E: 'Will the interventions implemented by CCHP increase the rate of routine early childhood immunizations for CCHP Medicaid members within the first 2 years of life who live in one of the identified "high risk" zip codes, as measured by an increase in the WIR 24-Month Benchmark result from 49.60% to 53.60% in MY2023?'
CCHP	Childhood Immunization Status	Aim F: 'Will the interventions implemented by CCHP increase the rate of routine early childhood immunizations for CCHP Medicaid members within the first 2 years of life who live in one of the identified "high risk" zip codes, as measured by an increase in the HEDIS CIS Combo #3 measure result from 45.13% to 49.13% in MY2023?'
CCHP	Childhood Immunization Status	Aim G: 'Will the interventions implemented by CCHP increase the rate of routine adolescent immunizations for CCHP Medicaid members who are between 11 and 13 years of age, as measured by an increase in the WIR Adolescent Benchmark result from 46.02% to 48.02% during MY2023?'
CCHP	Childhood Immunization Status	Aim H: 'Will the interventions implemented by CCHP increase the rate of routine adolescent immunizations for CCHP Medicaid members who are between 11 and 13 years of age, as measured by an increase in the HEDIS IMA Combo #2 measure result from 39.44% to 41.44% during MY2023?'
CCHP	Childhood Immunization Status	Aim I: 'Will the interventions implemented by CCHP increase the rate of routine adolescent immunizations for CCHP Medicaid members who are between 11 and 13 years of age who self-report their race as Black/African American, as measured by an increase in the WIR Adolescent Benchmark result from 41.77% to 44.77% in MY2023?'
CCHP	Childhood Immunization Status	Aim J: 'Will the interventions implemented by CCHP increase the rate of routine adolescent immunizations for CCHP Medicaid members who are between 11 and 13 years of age who self-report their race as Black/African American, as measured by an increase in the HEDIS IMA Combo #2 measure result from 29.79% to 32.79% in MY2023?'
CCHP	Childhood Immunization Status	Aim K: 'Will the interventions implemented by CCHP increase the rate of routine adolescent immunizations for CCHP Medicaid members who are between 11 and 13 years of age who live in one

MCO	Topic	Aim Statement
		of the identified “high risk” zip codes, as measured by an increase in the WIR Adolescent Benchmark result from 39.06% to 42.06% in MY2023?’
CCHP	Childhood Immunization Status	Aim L: ‘Will the interventions implemented by CCHP increase the rate of routine adolescent immunizations for CCHP Medicaid members who are between 11 and 13 years of age who live in one of the identified “high risk” zip codes, as measured by an increase in the HEDIS IMA Combo #2 measure result from 28.60% to 32.60% in MY2023?’
DHP	Prenatal and Postpartum Care	‘Through implementing proposed interventions that focus on Dean Health Plan’s underrepresented population (Black and Latinx BadgerCare Plus members), will Dean Health Plan improve overall postpartum care rates for Wisconsin BadgerCare Plus members from 80.52% in MY 2019 to 83.5% in MY 2023?’
DHP	Immunizations	Aim A: ‘This PIP seeks to improve DHP’s adolescent immunization rates. Through offering adolescent immunizations at vaccination clinics in the Black community, along with other initiatives, will DHP increase the BadgerCare Plus Immunizations for Adolescent Combination 2 rate from 36.78% in MY2021 to at least 41.12% in MY2023?’
DHP	Immunizations	Aim B: ‘This PIP seeks to improve DHP’s adolescent immunization rates. Through offering adolescent immunizations at vaccination clinics in the Black community, along with other initiatives, will DHP increase rate in Black members by 5% from 20.59% in MY2021 to 25.59% in MY2023?’
GHC-EC	Prenatal and Postpartum Care	‘The Cooperative will offer telehealth postpartum visits, through our partner clinic Oakleaf Health, to improve HEDIS PPC-postpartum care rates for BadgerCare Plus members identified as delivering a live birth between October 8, 2022, and October 7, 2023. We will improve rates of postpartum visit completion within 7 to 84 days following delivery from 82% (based on MY2021 performance) to achieve a rate at or above 83.8% (based on MY2023 performance).’
GHC-EC	Follow-Up After Hospitalization for Mental Illness	‘In 2023, the Cooperative’s partner clinic, Vantage Point, will provide telehealth outreach calls from a mental health provider to SSI Medicaid members discharged from a hospital for a mental health diagnosis. This improvement strategy is intended to improve HEDIS FUH-30 follow up rates for all SSI Medicaid members identified as being discharged from a mental health or intentional self-harm hospital stay between January 1 and December 1 of 2023. We will improve rates of follow up within 30 days of discharge from 66.2% (based on MY2021 performance) to

MCO	Topic	Aim Statement
		achieve a rate at or above the MY2022 DHS Goal (NCQA 75th percentile) rate of 67.5% (based on MY2023 performance).'
GHC-SCW	Prenatal and Postpartum Care	'By continuing MY2022 and new MY2023 improvement strategies that focus on the non-white population, GHC-SCW will improve overall postpartum care rates for Wisconsin BadgerCare Plus members from 78.26% in MY2019 to 84% in MY2023.'
GHC-SCW	Well-Child Visits	'GHC-SCW will improve the audited NCQA HEDIS Children and Adolescent Well-Care Visit (WCV) rate for its Medicaid members in the HEDIS WCV eligible population in calendar year (CY) 2023 from 48.93% in Calendar Year (CY) 2022 to the HEDIS 75th percentile. The HEDIS 75th percentile is 55.08% for CY2023, by conducting a Health Needs Assessment to facilitate coordination of care, identification of barriers to access, as well as completing additional outreach to members to connect them to care within 90 days of their enrollment.'
MCHP	Childhood Immunization Status	'MercyCare's goal was to increase the measurement year 2021 Combo 10 rate of 28.71% by 6.39% to bring it to 35.10% for measurement year 2023. 2.1 MercyCare performed an additional PIP intervention of a phone call to parents of members turning three months old, including discussion of the social determinants of health screening. 2.2 MercyCare's target population includes all active Medicaid members two years old and younger that have not received their Combo 10 immunizations by their second birthday. Calls are performed first to members who are Non-White and then second to members who are White.'
MCHP	Breast Cancer Screening	'Increase the breast cancer screening rates from 59.25% to 67.00%, for active female Medicaid members 50-74 years of age with a Mammogram ordered and not scheduled, by January 1, 2024 through phone outreach. 2.1 Phone outreach to members to schedule Mammogram appointment and collect significant drivers of health (SDoH) screening. 2.4 Focusing on non-white primarily, then white secondly. All are outreached.'
MHS	Prenatal and Postpartum Care	'Will the use of focused interventions (e.g., maternal community health worker (M-CHW) coaching program, community-based doula services, in-home or virtual behavioral health (BH) therapy services, grocery and meal services, and health literacy education) that are designed to address known social and health disparities

MCO	Topic	Aim Statement
		(e.g., food insecurity, low health literacy, and depressive symptoms) from January 1, 2023 to December 31, 2023 improve the PPC-postpartum care rate for all pregnant MHS Health BC+ members (study population) from 77.13% in MY2021 to 83.70% in MY2023 while also reducing health disparities?'
MHS	Asthma Management	'Will the use of focused interventions (e.g., Asthma CHW (A-CHW) coaching program, a digital monitoring device, and a mobile integrated healthcare partnership) that are designed to address known health disparities (e.g., food insecurity, education) from January 1, 2023 to December 31, 2023 improve the AMR rate for all SSI members with asthma (study population) from 63.48% in MY2021 to 73.27% in MY2023 while also reducing health disparities?'
MHWI	Prenatal and Postpartum Care	Aim A: 'By implementing tailored interventions that focus on the non-Hispanic African American/Black under-represented population, MHWI will improve the overall postpartum care rates for BC+ members from 68.61% in MY2021 to 81.27% (National Medicaid 75th Percentile in 2022 Quality Compass) in MY2023. MHWI will also improve the postpartum care disparity of non-Hispanic African American/Black Wisconsin BC+ members from 6.61% in MY2021 to less than 5% in MY2023. Interventions include removing barriers to accessing care by offering telehealth or in-home visits; exploring new engagement strategies through Community Health Worker member outreach, member incentives, and text messages; and partnering with a high-volume provider group who predominately serves the African American population.'
MHWI	Prenatal and Postpartum Care	Aim B: 'MHWI will also improve the postpartum care disparity of non-Hispanic African American/Black Wisconsin BC+ members from 6.61% in MY2021 to less than 5% in MY2023.'
MHWI	Diabetic Care	Aim A: 'MHWI will increase the HBD rate for SSI members from 53.38% (67th percentile*) in MY2021 to 54.26% (75th percentile*) in MY2023 by implementing interventions that increase A1c test completion; health education programs that engage members to reduce A1c values, including programs that partner with providers; and address unmet drivers of health needs. Update: Once MY2022 rates were finalized in June 2023, MHWI decided to increase the HBD SSI goal of 54.26% to 57.18% (75th percentile**) for MY2023 due to already surpassing initial PIP aim goal in MY2022. *Per Quality Compass released in 2022 for MY2021 National Medicaid Percentiles. **Per Quality Compass released in 2023 for MY2022 National Medicaid Percentiles'
MHWI	Diabetic Care	Aim B/C: 'Additionally, MHWI aims to reduce the disparities seen between the African American and the Hispanic populations to

MCO	Topic	Aim Statement
		less than 5% when comparing the individual rates for the under-represented populations to the overall HBD measure rate.'
MCW	Prenatal and Postpartum Care	'Through implementing planned care coordination interventions throughout 2023 that involve screening for DOH, addressing unmet DOH needs, partnering with provider clinics to offer PNCC and doula services, and focus on the African American population (targeting those residing in Milwaukee zip codes 53218 and 53205), My Choice WI (MCW) will improve the postpartum care rate for the BadgerCare Plus population from 63.99% in MY2021 to 67.19%* in MY2023. *A statistically significant increase based on using a chi-square test.'
MCW	Follow-Up After Hospitalization for Mental Illness	'In response to the need to increase compliance for SSI members with inpatient mental health visit follow-up appointments, My Choice Wisconsin will implement the following interventions: pre-discharge contacts with members, post-discharge assessments, and staff training to improve compliance of FUH from the MY2022 rate of 76.81% to 83.78% from January 1, 2023 to December 1st, 2023.'
NHP	Prenatal and Postpartum Care	'Will the use of focused interventions (e.g., maternal community health worker (M-CHW) coaching program, community-based doula services, in-home or virtual behavioral health (BH) therapy services, grocery and meal services, and health literacy education) that are designed to address known social and health disparities (e.g., food insecurity, low health literacy, and depressive symptoms) from January 1, 2023 to December 31, 2023 improve the PPC-postpartum care rate for all pregnant NHP BC+ members (study population) from 79.60% in MY2021 to 82.61% in MY2023 while also reducing health disparities?'
NHP	Hypertension and Diabetes	'Will the use of focused interventions (e.g., diabetes CHW coaching program, meal services) that are designed to address known health disparities (e.g., food insecurity) from January 1, 2023 to December 31, 2023, improve the HBD rate for all SSI members that are included into the HEDIS measure denominator (study population) from 48.18% in MY2021 (baseline) to 52.2% in MY2023 while also reducing health disparities?'
Quartz	Prenatal and Postpartum Care	'Through implementing interventions with a focus on Black or African American members, Quartz will improve overall PPC Prenatal Care rates from 86.62% in MY 2021 to 87.96% in MY 2023.'
Quartz	Diabetic Care	'Through implementing interventions that focus on Quartz Medicaid SSI members with diabetes, including a targeted focus on members of non-white races (Black or African American, American Indian, or Alaska Native, Native Hawaiian or Other

MCO	Topic	Aim Statement
		Pacific Islander and/or Asian) and Hispanic members, Quartz's Medicaid SSI MY2023 HEDIS HBD Control rate will be above the MY 2021 National Medicaid Quality Compass 75th percentile rate of 54.26%.'
SHP	Prenatal and Postpartum Care	Aim A: 'Through implementing interventions (SDoH screening and interventions by partner clinics, doula services, and utilization of FindHelp) that focus on underrepresented populations, Security Health Plan will improve: • overall postpartum care rates for Wisconsin BadgerCare Plus members from 84.91% in MY2019 to 85% in MY2023.'
SHP	Prenatal and Postpartum Care	Aim B: 'Through implementing interventions (SDoH screening and interventions by partner clinics, doula services, and utilization of FindHelp) that focus on underrepresented populations, Security Health Plan will improve: • rates for postpartum follow up care in the underrepresented population of African American members from 50% in MY2019 to 55% in MY2023.'
SHP	Prenatal and Postpartum Care	Aim C: 'Through implementing interventions (SDoH screening and interventions by partner clinics, doula services, and utilization of FindHelp) that focus on underrepresented populations, Security Health Plan will improve: • rates for postpartum follow up care in the underrepresented population of Asian members from 80% in MY2019 to 85% in MY2023.'
SHP	Diabetic Care	'Security Health Plan will improve the HBD HgA1C control rate for its SSI members whose race is non-white from 50% to 51.3% by December 31, 2023.'
UHC	Prenatal and Postpartum Care	'By December 31, 2023, through implementing disparity alleviation interventions that focus on the Black or African American population, UHCCP WI will: • Decrease the Index of Disparity for the HEDIS® PPC measure for UHCCP WI BC+ members from 7.535 in MY2021 at baseline to less than 5.000 in MY2023.'
UHC	Controlling Blood Pressure	'By December 31, 2023, through implementing disparity alleviation interventions that focus on improving blood pressure control in the Spanish speaking population, UnitedHealthcare Community Plan WI will: • Decrease the Index of Disparity for the HEDIS® Controlling High Blood Pressure measure for Wisconsin BC+ and SSI members from 15.692 in MY2020 at baseline to less than 5.000 in MY2023.'

Observation and Analysis: Standard 3. PIP Population

The MCOs 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 evaluated each PIP on two possible scoring elements. Collectively, the organizations satisfied requirements for 53 out of 56 scoring elements, for a score of 94.6 percent.

All but two projects clearly defined the PIP populations related to the aim statements, and the data collection approach captured all applicable members for all but one project.

Observation and Analysis: Standard 4. Sampling Method

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

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

MCOs must select variables that identify the MCO's 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 evaluated each PIP on 10 possible scoring elements. Collectively, the MCOs satisfied requirements for 179 out of 183 scoring elements, for a score of 97.8 percent.

Most organizations utilized HEDIS® measures for the projects. The PIP variables and performance measures were clear indicators of performance that addressed the aim statement. The variables for most projects were adequate to answer the PIP question. One project measured the aim statement through manual collection of data which was then inputted in the electronic care management system; however, the measure did not include a strategy to ensure inter-rater reliability of staff collecting and manually entering the data.

Observation and Analysis: Standard 6. Data Collection Procedures

MCOs 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 evaluated each PIP on 16 possible scoring elements. Collectively, the MCOs satisfied requirements for 310 out of 314 scoring elements, for a score of 98.7 percent.

All projects detailed a data collection process that ensured appropriate data would be available for the PIPs. Organizations documented the project's data collection procedures and ensured the procedures aligned with the data analysis. Most organizations utilizing HEDIS® hybrid measures ensured the accuracy and consistency of data collected from medical records by documenting the credentials, experience, and inter and intra-rater reliability process for staff collecting data.

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

MCOs 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 evaluated each PIP on eight possible scoring elements. Collectively, the MCOs satisfied requirements for 189 out of 212 scoring elements, for a score of 89.2 percent.

Scoring element 7.1 evaluated if the analysis was conducted in accordance with the data analysis plan. Projects conducted by Anthem and MCHP identified data analysis would occur more frequently than data was actually collected. While the reports described barriers to the collection of data on a more frequent basis, the data analysis plan was not updated to align with the frequency of data collection.

Scoring element 7.3 assessed the statistical significance of any differences between the initial and repeat measures. The MCOs, GHC-EC, MCHP, MHWI, and Quartz, did not incorporate statistical testing of differences between the initial and repeat measurements, or did not conduct statistical testing when rates declined.

Scoring element 7.6 evaluated if the PIP compared the results across multiple entities such as different patient subgroups, provider sites, or MCOs. One organization, MCHP, reported data was collected on comparison groups of members, but did not include a calculated rate for the comparison groups. Two other MCOs, GHC-SCW and Quartz, did not collect data on comparison groups for one of the projects each organization conducted.

Scoring element 7.7 ensured report findings were presented in a concise and easily understood manner. Three MCOs, GHC-SCW, GHC-EC, and MHS, included inconsistent rates for the baseline

or repeat measures within the PIP report. The organization, MCHP, included graphics that did not clearly reflect the process for calculating the final results of the project. Another organization, NHP, included references to the incorrect measure for the project; therefore, it was unclear if the information was applicable to the PIP project. Quartz identified the use of the HEDIS® measure specifications for the project, but documented the use of a similar measure as the performance indicator and data collection method for the project.

Observation and Analysis: Standard 8. Improvement Strategies

MCOs 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 evaluated each PIP on six possible scoring elements. Collectively, the MCOs satisfied requirements for 153 out of 168 scoring elements, for a score of 91.1 percent.

Most of the organizations utilized evidence-based improvement strategies and continuous cycles of improvement to test the effectiveness of the strategies. All but one project utilized improvement strategies that were culturally and linguistically appropriate.

The improvement strategies associated with each aim are identified below along with the effectiveness of the strategy as determined by the MCOs. The following ratings for effectiveness are applied to each strategy.

Improvement Strategy Effectiveness Ratings	
Effective	MCO indicated strategy was effective.
Not Effective	MCO indicated strategy was not effective.
No Evaluation	MCO could not determine if it was effective, or there was no evaluation of the effectiveness.
Not Implemented	MCO did not implement the strategy.

There were no state-required topics and there were no state-required improvement strategies.

MCO	Topic	Improvement Strategies	Effectiveness
Anthem	Prenatal and Postpartum Care	Expanded collaborative relationships and events with four clinics or community-based organizations to enhance maternal care.	Effective
Anthem	Prenatal and Postpartum Care	Offered doula services to PIP participants.	Effective

MCO	Topic	Improvement Strategies	Effectiveness
Anthem	Prenatal and Postpartum Care	Offered value-added benefits to members through incentive programs such as the Healthy Rewards program.	Effective
Anthem	Prenatal and Postpartum Care	Focused on addressing the main social determinant of health (SDoH) issue of transportation by offering transportation cards to members to attend prenatal, postpartum, and well-child education visits.	Not Effective
Anthem	Prenatal and Postpartum Care	Provided case management and maternal child services resources to members.	Effective
Anthem	Follow-Up After High-Intensity Care for Substance Use Disorder	Provided medication assistance training to providers treating members diagnosed with substance use disorder.	Effective
Anthem	Follow-Up After High-Intensity Care for Substance Use Disorder	Offered members value added benefits of incentives or rewards to access follow-up care.	Effective
Anthem	Follow-Up After High-Intensity Care for Substance Use Disorder	Utilized a targeted case management approach for members with substance use disorder.	Effective
Anthem	Follow-Up After High-Intensity Care for Substance Use Disorder	Offered resources to members to address SDoH needs.	Effective
CCHP	Prenatal and Postpartum Care	Referred members to Milwaukee County Health Start for screening and care coordination services.	Effective
CCHP	Prenatal and Postpartum Care	Engaged members in case management services through the Healthy Mom Health Baby program.	Effective
CCHP	Prenatal and Postpartum Care	Conducted postpartum care visits by the CCHP Community Outreach Nurse Practitioner.	Effective
CCHP	Prenatal and Postpartum Care	Entered into a pilot program with Birth and Embrace Communities, Inc. to refer members to doula services.	Effective
CCHP	Prenatal and Postpartum Care	Partnered with a community-based organization, Social Development Commission, to trial ways to engage with members via the 53206 Project, located in the central part of the city of Milwaukee, Wisconsin.	Not Effective

MCO	Topic	Improvement Strategies	Effectiveness
CCHP	Prenatal and Postpartum Care	Implemented a drivers of health improvement assessment tool.	Not Implemented
CCHP	Prenatal and Postpartum Care	Developed a health disparities plan for CCHP.	Effective
CCHP	Prenatal and Postpartum Care	Partnered with the St. Joseph's Women's Outpatient Center, on methods to reduce health disparities.	Effective
CCHP	Childhood Immunization Status	Conducted outreach to members by mailing reminders for HealthCheck appointments, educational materials about immunizations, and telephonic and text messaged reminders to obtain routine immunizations.	Effective
CCHP	Childhood Immunization Status	Conducted targeted outreach strategies targeted to members identified as at highest risk for remaining unvaccinated due to racial/ethnic or geographical disparities, including monthly live telephonic outreach reminders about preventive care, including routine immunizations.	Effective
CCHP	Childhood Immunization Status	Collaborated with external partners to support and promote immunizations efforts in community settings.	Effective
DHP	Prenatal and Postpartum Care	Offered case management services to members to provide pregnancy support and education to members to ensure members are connected to necessary care.	Effective*
DHP	Prenatal and Postpartum Care	Offered community-based doulas trained to bridge language and cultural barriers of pregnant Black and Latinx members.	Effective
DHP	Prenatal and Postpartum Care	Requested stakeholder and member feedback on a regular basis to evaluate options for expansion of doula services.	Effective*
DHP	Prenatal and Postpartum Care	Operationalized cultural competency trainings for MCO staff.	Effective*
DHP	Prenatal and Postpartum Care	Partnered with clinics and the Dane County Health Council to obtain additional SDoH information to improve prenatal care in Dane County, Wisconsin.	Effective*
DHP	Prenatal and Postpartum Care	Offered additional transportation services to members served by doulas to address SDoH needs of these members.	Effective*
DHP	Immunizations	Published quarterly *CheckUp n*ewsletters to members that included important information about their health care, including child and adolescent immunizations.	No Evaluation
DHP	Immunizations	Conducted outreach to educate parents of the importance of adolescent immunizations.	No Evaluation

MCO	Topic	Improvement Strategies	Effectiveness
DHP	Immunizations	Conducted a social media vaccine campaign to encourage families to get caught up on immunizations and well-child visits.	Effective
DHP	Immunizations	Offered an adolescent immunization incentive program to members.	Effective
DHP	Immunizations	Hosted vaccine events and mobile vaccine clinics with trusted community-based organizations in attempts to address the distrust of the health care system.	Effective
GHC-EC	Prenatal and Postpartum Care	Offered telehealth postpartum visits through a partner clinic, Oakleaf Health.	Effective
GHC-EC	Follow-Up After Hospitalization for Mental Illness	Offered telehealth outreach calls from a community-based mental health provider, Vantage Point.	Not Effective
GHC-SCW	Prenatal and Postpartum Care	Followed the Health Disparities Reduction Plan that began in 2022 with second partner clinic, GHC-SCW Capitol Clinic.	Effective
GHC-SCW	Prenatal and Postpartum Care	Conducted staff trainings on health disparities.	Effective
GHC-SCW	Prenatal and Postpartum Care	Obstetrics team interviewed BC+ members.	Effective
GHC-SCW	Prenatal and Postpartum Care	Developed a partnership with St. Vincent DePaul.	Effective
GHC-SCW	Prenatal and Postpartum Care	Provided health equity training to Hatchery Hill.	Effective
GHC-SCW	Prenatal and Postpartum Care	Provided gift cards to incentivize postpartum visit attendance.	Effective
GHC-SCW	Prenatal and Postpartum Care	Provided doula services to LatinX Badger Care Plus members.	Effective
GHC-SCW	Well-Child Visits	Completion of health needs assessment.	Not Effective
MCHP	Childhood Immunization Status	Conducted telephonic outreach to parents of members age three months old.	Effective
MCHP	Childhood Immunization Status	Mailed letters to members who had missing immunizations at nine months and 19 months of age.	Effective*
MCHP	Childhood Immunization Status	Partnered with Mercyhealth System East Clinic Family Practice and Pediatrics in Janesville to create a social determinant of health needs assessment for members.	Not Implemented

MCO	Topic	Improvement Strategies	Effectiveness
MCHP	Childhood Immunization Status	Continued a community-based organization business agreement with Children's Wisconsin Rock County Family Resource Center, to connect families with community resources.	Effective*
MCHP	Breast Cancer Screening	Conducted telephonic outreach to members.	Effective
MCHP	Breast Cancer Screening	Mailed reminder letters to members about obtaining a breast cancer screening.	Effective
MCHP	Breast Cancer Screening	Perform a lunch and learn meeting at clinics to inform providers on the outstanding need of mammograms for MCHP patients.	Not Implemented
MHS	Prenatal and Postpartum Care	Provided maternal community health worker care coordination services.	Effective
MHS	Prenatal and Postpartum Care	Offered community-based doula services.	Effective
MHS	Prenatal and Postpartum Care	Offered virtual doula services.	Effective
MHS	Prenatal and Postpartum Care	Provided a prenatal and postpartum food pilot program.	Effective
MHS	Prenatal and Postpartum Care	Offered in-home or virtual postpartum behavioral health therapy services.	No Evaluation
MHS	Asthma Management	Provided asthma community health worker care coordination services.	Effective
MHS	Asthma Management	Offered a digital monitoring device.	Effective
MHS	Asthma Management	Partnered with the Milwaukee Fire Department Mobile Integrated Healthcare program.	Not Implemented
MHWI	Prenatal and Postpartum Care	Partnered with ProCare Medical.	Effective
MHWI	Prenatal and Postpartum Care	Provided Community Connector outreach services.	Effective
MHWI	Prenatal and Postpartum Care	Provided Care Connections team services to members.	Effective
MHWI	Prenatal and Postpartum Care	Provided an incentive program to members.	Effective
MHWI	Prenatal and Postpartum Care	Conducted a disparities reduction plan.	Effective
MHWI	Prenatal and Postpartum Care	Implemented value-based contracts with providers to increase provider engagement around quality measures.	Effective

MCO	Topic	Improvement Strategies	Effectiveness
MHWI	Prenatal and Postpartum Care	Completed and tracked SDoH screenings.	Effective
MHWI	Diabetic Care	Provided A1c at home kits.	Effective
MHWI	Diabetic Care	Provided Care Connections visits.	Effective
MHWI	Diabetic Care	Partnered with ProCare Medical to provide A1c point of care testing.	Effective
MHWI	Diabetic Care	Offered A1c test incentives.	Not effective
MHWI	Diabetic Care	Completed text messaging through Relay.	Effective
MHWI	Diabetic Care	Collected data via the electronic medical record feed from additional providers.	Effective
MHWI	Diabetic Care	Conducted additional year-round medical record reviews.	Effective
MHWI	Diabetic Care	Implemented a care kit program.	Not Effective
MHWI	Diabetic Care	Provided diabetes champion program.	Not Effective
MHWI	Diabetic Care	Developed a partnership with Advocate Aurora.	Effective
MHWI	Diabetic Care	Completed health risk assessments.	Effective
MHWI	Diabetic Care	Provided Community Connector services.	Effective
MHWI	Diabetic Care	Partnered with Milwaukee County Housing Division to provide Housing Navigator program.	Effective
MCW	Prenatal and Postpartum Care	Partnered with ProCare Medical Group and Sixteenth Street Clinic to improve communication regarding notification of pregnant members.	Effective
MCW	Prenatal and Postpartum Care	Completed SDoH screenings.	Effective
MCW	Prenatal and Postpartum Care	Offered doula services.	Effective
MCW	Prenatal and Postpartum Care	Collaborated with Pampered Darlings to connect members with resources.	Effective
MCW	Follow Up After Hospitalization for Mental Illness	Created a training regimen to establish the use of the pre-discharge template when MCO staff contacted member's prior to hospital discharge.	Not Effective
MCW	Follow Up After Hospitalization for Mental Illness	Developed a pre-discharge template for MCO staff to use when meeting with members prior to hospital discharge, which was focused on addressing SDoH needs of members.	Not Effective

MCO	Topic	Improvement Strategies	Effectiveness
MCW	Follow Up After Hospitalization for Mental Illness	Utilized a post-discharge care transition assessment to ensure a follow-up appointment was scheduled with a mental health provider.	Not Effective
NHP	Prenatal and Postpartum Care	Provided maternal community health worker care coordination services.	Effective
NHP	Prenatal and Postpartum Care	Offered community-based doula services.	Not Effective
NHP	Prenatal and Postpartum Care	Offered virtual doula services.	Effective
NHP	Prenatal and Postpartum Care	Provided a prenatal and postpartum food pilot program.	Effective
NHP	Prenatal and Postpartum Care	Offered in-home or virtual postpartum behavioral health therapy services.	No Evaluation
NHP	Hypertension and Diabetes	Provided diabetes community health worker care coordination services.	Effective
NHP	Hypertension and Diabetes	Provided a diabetes food pilot program.	Effective
NHP	Hypertension and Diabetes	Partnered with the Hayat Pharmacy program.	Not Effective
Quartz	Prenatal and Postpartum Care	Implemented Quartz Healthy Beginnings program.	Effective
Quartz	Prenatal and Postpartum Care	Offered services through the OB Medical Home (OBMH).	No Evaluation
Quartz	Prenatal and Postpartum Care	Offered services through Dane County ConnectRx.	No Evaluation
Quartz	Prenatal and Postpartum Care	Implemented Prenatal Care Coordination (PNCC).	No Evaluation
Quartz	Diabetic Care	Implemented care management outreach.	No Evaluation
Quartz	Diabetic Care	Implemented HbA1c care gap closure outreach.	No Evaluation
Quartz	Diabetic Care	Offered services through Virta Digital Diabetes Care Management program.	No Evaluation
SHP	Prenatal and Postpartum Care	Partnered with two clinics to offer doula services to all pregnant members.	Effective*
SHP	Prenatal and Postpartum Care	Mailed educational materials to all pregnant members prior to and after giving birth.	Effective*

MCO	Topic	Improvement Strategies	Effectiveness
SHP	Prenatal and Postpartum Care	Collaborated with county health departments to improve prenatal and postpartum care for members.	Effective*
SHP	Prenatal and Postpartum Care	Addressed social determinants of health (SDoH) needs of members through referrals to county health departments or community resource departments at partner clinics.	Effective*
SHP	Prenatal and Postpartum Care	Promoted telehealth visits to close postpartum gaps in care.	Effective*
SHP	Prenatal and Postpartum Care	Provided targeted services to high-risk pregnant women, including assistance with tobacco cessation.	Effective*
SHP	Prenatal and Postpartum Care	Hired a dedicated Health Equity, Diversity and Inclusion Coordinator to further improve collaboration with one of the partner clinics.	Effective*
SHP	Prenatal and Postpartum Care	Collaborated with the partner clinics and *FindHelp*, a web-based SDoH software vendor, to assist with screening and connecting individuals seeking support related to SDoH needs.	Effective*
SHP	Prenatal and Postpartum Care	Utilized community health workers through the partner clinics to connect members with resources for SDoH needs.	Effective*
SHP	Prenatal and Postpartum Care	Screened members for SDoH needs.	Effective*
SHP	Diabetic Care	Offered and implemented *Omada for Diabetes*, a digital solution and platform program, to SSI members with diabetes.	Effective*
SHP	Diabetic Care	Conducted outreach efforts to encourage members to enroll in the *Omada for Diabetes* program.	Effective*
SHP	Diabetic Care	Partnered with a community-based organization, Marshfield Clinic Health System, in implementing *FindHelp.*	Effective*
UHC	Prenatal and Postpartum Care	Utilized UHC maternity community health workers to educate and support members up to eight weeks postpartum.	Not Effective
UHC	Prenatal and Postpartum Care	Referred Black/African American members to the WeRISE community doula program.	Not Implemented
UHC	Prenatal and Postpartum Care	Partnered with UniteWI to provide community health workers to pregnant members in Milwaukee County, Wisconsin.	Not Effective
UHC	Prenatal and Postpartum Care	Referred members to Wellhop, an online peer support group.	Effective
UHC	Prenatal and Postpartum Care	Offered Vivify remote patient monitoring to pregnant members.	Not Effective

MCO	Topic	Improvement Strategies	Effectiveness
UHC	Prenatal and Postpartum Care	Conducted a drivers of health needs assessment with pregnant and postpartum Black/African American members to identify needs and refer members to community resources through FindHelp.	Effective
UHC	Prenatal and Postpartum Care	Offered the Mom's Meals meal delivery program to newly postpartum Black/African American members who reported food insecurity.	Effective
UHC	Controlling Blood Pressure	Reassigned members to culturally competent primary care physicians.	Not Implemented
UHC	Controlling Blood Pressure	Partnered with Outagamie FoodWise to provide educational classes to Hispanic and Spanish speaking members near Appleton, Wisconsin.	Effective
UHC	Controlling Blood Pressure	Offered Vivify remote patient monitoring to targeted Spanish speaking members with uncontrolled hypertension.	Effective
UHC	Controlling Blood Pressure	Conducted a drivers of health needs assessment with members with uncontrolled hypertension.	Effective
UHC	Controlling Blood Pressure	Offered the FarmBox RX fresh food delivery program with traditionally Hispanic produce to members.	Effective

**Effectiveness of the improvement strategy was identified during the interview, but was not included in the PIP report*.

Observation and Analysis: Standard 9. Significant and Sustained Improvement

An important component of a PIP is to demonstrate sustained improvement. The MCOs 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 MCOs satisfied requirements for 74 out of 100 scoring elements, for a score of 74.0 percent.

All but one project utilized the same methodology for the baseline and repeat measures of the project.

Scoring element 9.2 evaluated if there was quantitative evidence of improvement. Projects completed by CCHP and MHWI had more than one aim statement and quantitative improvement was reflected in some but not all of the project's aim statements. Projects completed by GHC-EC, MCHP, MCW, Quartz, SHP, and UHC had one aim statement and did not achieve quantitative improvement from baseline to remeasurement for the project.

Scoring element 9.3 evaluated if the reported improvement in performance was likely to be a result of the selected intervention. Quartz reported an improvement in the final rate; however, the baseline rate was not comparable to the repeat measure. Due the lack of comparability, the MCO could not then determine if the change in rates was due to the project's interventions. One of *i*Care's projects reflected improvement from the baseline rate; however, the intervention was not implemented and improvement then could not be linked to implementation of an intervention.

Scoring element 9.4 evaluated if there was statistical evidence that any observed improvement was the result of the interventions. The MCOs, MCHP and Quartz, did not complete statistical testing to determine if the rate of improvement was the result of the interventions.

Scoring element 9.5 evaluated if sustained improvement was demonstrated through repeated measurements over time. Multi-year projects conducted by DHP, GHC-EC, GHC-SCW, MHS, NHP, SHP, and UHC did not reflect continued improvement for baseline for each year of the project.

Significant Improvement

The significant improvement rating was determined by MetaStar through the use of a statistical test using the project's baseline and repeat measurement for the aim statement. If there are multiple aim statements, testing is completed on each aim and the lowest rating achieved is the significant improvement rating for the project. Data used by the MCO to determine baseline and repeat measurements was submitted to MetaStar for the evaluation. The results are outlined below.

MCO	Topic	Baseline Measurement	Repeat Measurement	Significant Improvement Rating
Anthem	Prenatal and Postpartum Care	38 postpartum visits/58 live births	56 postpartum visits/75 live births	Low Confidence
Anthem	Follow-Up After High-Intensity Care for Substance Use Disorder	3 members with substance use disorder follow up visits within 30 days/12 members with an acute inpatient discharge, residential discharge, or withdrawal management event during the measurement year	14 members with substance use disorder follow up visits within 30 days/23 members with an acute inpatient discharge, residential discharge, or withdrawal management event during the measurement year	Moderate Confidence
CCHP Aim A	Prenatal and Postpartum Care	242 members who had postpartum visits/313 live births	353 members who had postpartum visits/411 live births	Moderate Confidence

MCO	Topic	Baseline Measurement	Repeat Measurement	Significant Improvement Rating
CCHP Aim B	Prenatal and Postpartum Care	100 African American members who had postpartum visits/137 African American members who had live births	142 African American members who had postpartum visits/173 African American members who had live births	Low Confidence
CCHP Aim A	Childhood Immunization Status	3,138 members up to age two immunized/5,306 members up to age two	2,756 members up to age two immunized/4,452 members up to age two	Moderate Confidence
CCHP Aim B	Childhood Immunization Status	238 members up to age two immunized/411 members up to age two	251 members up to age two immunized/411 members up to age two	Low Confidence
CCHP Aim C	Childhood Immunization Status	967 African American members up to age two immunized/1,833 African American members up to age two	836 African American members up to age two immunized/1,532 African American members up to age two	Low Confidence
CCHP Aim D	Childhood Immunization Status	494 African American members up to age two immunized/1,029 African American members up to age two	57 African American members up to age two immunized/120 African American members up to age two	No Confidence
CCHP Aim E	Childhood Immunization Status	614 “high risk” zip code members up to age two immunized/1,238 “high risk” zip code members up to age two	492 “high risk” zip code members up to age two immunized/987 “high risk” zip code members up to age two	Low Confidence
CCHP Aim F	Childhood Immunization Status	436 “high risk” zip code members up to age two immunized/966 “high risk” zip code members up to age two	45 “high risk” zip code members up to age two immunized /112 “high risk” zip code members up to age two	No Confidence
CCHP Aim G	Childhood Immunization Status	3,121 members age 11-13 immunized/6,782 members age 11-13	2,568 members age 11-13 immunized/6,838 members age 11-13	No Confidence
CCHP Aim H	Childhood Immunization Status	1,804 members age 11-13 immunized/4,574 members age 11-13	1,853 members age 11-13 immunized/4,787 members age 11-13	No Confidence
CCHP Aim I	Childhood Immunization Status	903 African American members age 11-13 immunized/2,162 African American members age 11-13	723 African American members age 11-13 immunized/2,107African American members age 11-13	No Confidence
CCHP Aim J	Childhood Immunization Status	463 African American members age 11-13 immunized/1,554 African American members age 11-13	469 African American members age 11-13 immunized/1,519 African American members age 11-13	Low Confidence

MCO	Topic	Baseline Measurement	Repeat Measurement	Significant Improvement Rating
CCHP Aim K	Childhood Immunization Status	584 “high risk” zip code members age 11-13 immunized/1,495 “high risk” zip code members age 11-13	489 “high risk” zip code members age 11-13 immunized/1,464 “high risk” zip code members age 11-13	No Confidence
CCHP Aim L	Childhood Immunization Status	316 “high risk” zip code members age 11-13 immunized/1,105 “high risk” zip code members age 11-13	350 “high risk” zip code members age 11-13 immunized/1,075 “high risk” zip code members age 11-13	Moderate Confidence
DHP	Prenatal and Postpartum Care	339 postpartum visits/421 live births	229 postpartum visits/260 live births	Moderate Confidence
DHP Aim A	Immunizations	512 BC+ children who completed required immunizations/1,392 BC+ children who turned 13 during the measurement year	171 BC+ children who completed required immunizations/411 BC+ children who turned 13 during the measurement year	Low Confidence
DHP Aim B	Immunizations	17 Black BC+ children who completed required immunizations/34 Black BC+ children who turned 13 during the measurement year	21 Black BC+ children who completed required immunizations/46 Black BC+ children who turned 13 during the measurement year	Low Confidence
GHC-EC	Prenatal and Postpartum Care	337 postpartum visits/411 live births	361 postpartum visits/411 live births	Moderate Confidence
GHC-EC	Follow-Up After Hospitalization for Mental Illness	45 mental health provider visits within 30-days of discharge/68 acute inpatient discharges	25 mental health provider visits within 30-days of discharge/48 acute inpatient discharges	No Confidence*
GHC-SCW	Prenatal and Postpartum Care	72 members with a postpartum visit/92 live births	93 members with a postpartum visit/116 live births	Low Confidence
GHC-SCW	Well-Child Visits	1,095 members with a well-care visit/2,680 eligible members	1,063 members with a well-care visit/2,506 eligible members	Low Confidence
MCHP	Childhood Immunization Status	118 members received all childhood Combo 10 immunizations/411 members who are two years of age	87 members received all childhood Combo 10 immunizations/344 members who are two years of age	No Confidence
MCHP	Breast Cancer Screening	Baseline provided was not reported according to the aim statement.	Repeat measurement provided was not reported according to the aim statement.	No Confidence*

MCO	Topic	Baseline Measurement	Repeat Measurement	Significant Improvement Rating
MHS	Prenatal and Postpartum Care	253 postpartum visits/328 live births	326 postpartum visits/411 live births	Low Confidence
MHS	Asthma Management	73 members with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater/115 members with a diagnosis of asthma	69 members with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater/92 members with a diagnosis of asthma	Low Confidence
MHWI Aim A	Prenatal and Postpartum Care	282 postpartum visits/411 live births	222 postpartum visits/270 live births	High Confidence
MHWI Aim B	Prenatal and Postpartum Care	120 postpartum visits of non-Hispanic African American/Black members/195 non-Hispanic African American/Black members with a live birth	98 postpartum visits of non-Hispanic African American/Black members/130 non-Hispanic African American/Black members with a live birth	Moderate Confidence
MHWI Aim A	Diabetic Care	158 members aged 18-75 with diabetes whose HbA1c was less than 8 percent/296 members with a diagnosis of diabetes	176 members aged 18-75 with diabetes whose HbA1c was less than 8 percent/286 members with a diagnosis of diabetes	Moderate Confidence
MHWI Aim B	Diabetic Care	41 African-American members with diabetes whose HbA1c less than 8 percent/87 African-American members with a diagnosis of diabetes	60 African-American members with diabetes whose HbA1c less than 8 percent/95 African-American members with a diagnosis of diabetes	Moderate Confidence
MHWI Aim C	Diabetic Care	16 Hispanic members with diabetes whose HbA1c less than 8 percent/37 Hispanic members with a diagnosis of diabetes	19 Hispanic members with diabetes whose HbA1c less than 8 percent/37 Hispanic members with a diagnosis of diabetes	Low Confidence
MCW	Prenatal and Postpartum Care	265 postpartum visits/411 live births	264 postpartum visits/367 live births	Moderate Confidence
MCW	Follow-Up After Hospitalization for Mental Illness	53 mental health provider visits within 30-days of discharge/69 acute inpatient discharges	28 mental health provider visits within 30-days of discharge/38 acute inpatient discharges	No Confidence
NHP	Prenatal and Postpartum Care	277 postpartum visits/348 live births	344 postpartum visits/411 live births	Low Confidence
NHP	Hypertension and Diabetes	198 members aged 18-75 with diabetes whose HbA1c was less than 8 percent/411	235 members aged 18-75 with diabetes whose HbA1c was less than 8 percent/384	High Confidence

MCO	Topic	Baseline Measurement	Repeat Measurement	Significant Improvement Rating
		members with a diagnosis of diabetes	member with a diagnosis of diabetes	
Quartz	Prenatal and Postpartum Care	356 prenatal visits/411 live births	207 prenatal visits/250 live births	No Confidence
Quartz	Diabetic Care	2021 National Medicaid Quality Compass 75th percentile	9 members who had an HbA1c test completed in 2023 and the results were below eight percent/13 members with diabetes at any time during 2023	No Confidence*
SHP Aim A	Prenatal and Postpartum Care	349 postpartum visits/411 live births	212 postpartum visits/260 live births	No Confidence
SHP Aim B	Prenatal and Postpartum Care	2 postpartum visits/4 live births	3 postpartum visits/5 live births	Low Confidence
SHP Aim C	Prenatal and Postpartum Care	16 postpartum visits/20 live births	9 postpartum visits/11 live births	Low Confidence
SHP	Diabetic Care	0 members with diabetes in control (A1c of less than eight percent)/ 0 members whose race was non-White	0 members with diabetes in control (A1c of less than eight percent)/ 4 members whose race was non-White	No Confidence
UHC	Prenatal and Postpartum Care	352 postpartum visits/411 live births	332 postpartum visits/411 live births	No Confidence
UHC	Controlling Blood Pressure	537 members with controlled blood pressure/822 members with a diagnosis of hypertension	599 members with controlled blood pressure/822 members with a diagnosis of hypertension	High Confidence

** Significant improvement could not be determined due to a different methodology used for the baseline and repeat measurement.*

Prepaid Inpatient Health Plans

The validation ratings for each PIHP PIP project are identified below. The methodology section includes a table listing each standard that was evaluated for the PIP methodology. The table indicates the total number of scoring elements for all PIHP PIP projects and the percentage of scoring elements met in all PIHP projects for each standard, which determined the methodology rating. Not all scoring elements apply to every project, which makes the total applicable elements for each project different. Scoring elements that are not applicable are identified as 'N/A.' The significant improvement section details the outcome for the aim(s) of each project.

Methodology

MetaStar's confidence that the PIHP PIPs adhered to acceptable methodology for all phases was moderate.

CY 2024 (MY 2023) Methodology Rating – Prepaid Inpatient Health Plans			
Standards	**Scoring Elements**	**Percentage**	**Methodology Rating**
Standard 1: PIP Topic	13/13	100.0%	High Confidence
Standard 2: PIP Aim Statement	27/30	90.0%	High Confidence
Standard 3: PIP Population	10/10	100.0%	High Confidence
Standard 4: Sampling Method*	N/A	N/A	N/A
Standard 5: PIP Variables and Performance Measures	24/27	88.9%	Moderate Confidence
Standard 6: Data Collection Procedures	36/37	97.3%	High Confidence
Standard 7: Data Analysis and Interpretation of PIP Results	25/36	69.4%	No Confidence
Standard 8: Improvement Strategies	20/29	69.0%	No Confidence
Standard 9: Significant and Sustained Improvement	7/14	50.0%	No Confidence
Methodology Rating	**162/196**	**82.7%**	**Moderate Confidence**

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

Observation and Analysis: Standard 1. PIP Topic

The PIHPs 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 evaluated each PIP on five possible scoring elements. Collectively, the PIHPs satisfied requirements for 13 out of 13 scoring elements, for a score of 100.0 percent.

All topics included an analysis of topic selection and the importance to PIHP members. Topics addressed priority areas and included enrollee and provider input when applicable.

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 evaluated each PIP on six possible scoring elements. Collectively, the PIHPs satisfied requirements for 27 out of 30 scoring elements, for a score of 90.0 percent.

Aim statements for all PIHP projects included the required criteria, with the exception of one project which did not clearly specify the time period for the PIP. The aim statement for this project was not answerable as the time period was not specified. All aim statements were concise.

The table below identifies the aim statements for each clinical PIP topic. The aim statements in the table are copied from the PIP reports submitted by the organizations. No adjustments or edits were made by MetaStar.

PIHP	Topic	Aim Statement
CCF	Program Transition	'The project aim was to increase the percentage of CCF disenrollees who subsequently enrolled in a DCDHS mental health/substance Abuse (MH/SA) program within 3 months of CCF disenrollment from 35%* to 60%, by comparing CCF participants who disenrolled during a 7.5 month period prior to the announcement of CCF sunsetting (April 1, 2022-Nov. 14, 2022) versus the CCF transition to sunsetting period (Nov. 15, 2022-June 30, 2023), as marked by an intervention beginning Nov. 15, 2022 leveraging Care Coordinators in assisting families in selecting and enrolling in their preferred service, and following up with families 30 days after CCF disenrollment to ensure there were no concerns or challenges with the transition to the new program. *Note: In the original PIP proposal, the pre-intervention baseline was reported as 30%. This is because two youth who subsequently enrolled in another DCDHS MH/SA program within 3 months of their CCF disenrollment, did so 1/19/2023 and 1/26/2023, which was after the proposal had already been written, but within 3 months of disenrollment for those two youth.'
CCHP	Mental Health Evaluations	'Increase the percentage of Care4Kids members who have an outpatient visit with a mental health provider within 30 days of a mental health inpatient hospitalization from 50% to 67% throughout the measurement year of 2023. This will be achieved in 2 ways. Staff will utilize the Care4Kids Internal Behavioral Health Therapist during the process of when a member is admitted to and discharged from a mental health facility to ensure that the member receives the appropriate outpatient

PIHP	Topic	Aim Statement
		service once back in the community. Procedural codes HEDIS utilizes will be reviewed to determine what is considered an outpatient visit to ensure the program is capturing all areas of services that can be utilized.'
CCHP	Care Transitions	'Improvement Strategy: Decrease the percentage of ICHE barriers related to access from 46% to 35%. This will be achieved by: o Establish an internal Care4Kids Care Coordination Workgroup to identify and implement best practice for ICHE tracking and how to address barriers before finding out about them at a later date. o Barriers related to access include the following ICHE Non-Timely Reasons - Earlier appointment offered but Caregiver/Child Welfare Worker/Youth could not bring youth - Provider unavailable for an earlier appointment o Conducting an assessment on how to communicate out changes when providers change practices. – Population: All newly enrolled children in the Care4Kids program in 2023 who have a completed non-timely ICHE that was due in the 2023 measurement year. – Time Period: ICHE dates between February 1, 2023 and January 30, 2024. The ICHE measure uses enrollment dates for inclusion into the metric, however the exams are due 30-days after enrollment so the time period for exam due dates runs from February to January for the 2023 measurement year. Note that this is still one year of data. Baseline data used for this PIP was for the 2021 measurement year (ICHEs due between February 1, 2021 and January 30, 2022).'
WM	AODA Services	'Within the context of the entire PIP timeframe (March 1, 2023 – December 31, 2023), 100% of newly enrolled youth, who have been identified as potentially benefiting from AODA services through a two-tiered assessment process which includes a single brief screen AODA question and collateral information gathered during screening, and if applicable followed by the results from the Brief Screener for Tobacco, Alcohol and Other Drugs (BSTAD) which identifies risk level (No Risk, Lower Risk or High Risk), will be provided with educational information about drug use and abuse and a list of AODA providers, resulting in 30% of those youth receiving AODA services (5% increase from the baseline of 25% receiving services) within 30 days of referral.'

PIHP	Topic	Aim Statement
WM	Literacy	Aim A: 'In Phase I (beginning January 2023 for 4 months with variable start dates) face-to-face phonics instruction will be provided once a week to Wraparound Milwaukee youth who have been placed in the Boost or Fast Boost instructional program with a possible absolute instructional dosage of 16 hours that will result in an average increase of 10% of phonic proficiency as measured by the DIBELS Oral Reading Fluency Assessment (Words Correct per Minute & Accuracy) compared to the overall average DIBELS Oral Reading Fluency (Words Correct per Minute & Accuracy) baseline score of 151.'
WM	Literacy	Aim B: 'In Phase II (dependent on when youth begin the 2nd 4 months, ending no later than December 31, 2023) phonics instruction will be provided on a virtual platform, once a week to Wraparound Milwaukee youth who have been placed in the Boost or Fast Boost instructional program with a possible absolute instructional dosage of 16 hours that will result in an average increase of 10% of phonic proficiency as measured by the DIBELS Oral Reading Fluency Assessment (Words Correct per Minute & Accuracy) compared to the average assessment outcomes measured by the DIBELS at the end of Phase I.* * Thresholds of progress for the 2 study questions are based on the outcomes of the 2022 PIP.'

Observation and Analysis: Standard 3. PIP Population

The PIHPs must clearly define the project's population, identifying all inclusionary and exclusionary criteria. If the entire eligible PIHPs population is included in the project, the data collection approach must ensure it captures all applicable members. Standard 3 evaluated each PIP on two possible scoring elements. Collectively, the organizations satisfied requirements for 10 out of 10 scoring elements, for a score of 100.0 percent.

The organizations clearly defined the projects' populations. Inclusion and exclusion criteria were delineated in the reports to ensure projects included all eligible members specified in the aim statement.

Observation and Analysis: Standard 4. Sampling Method

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

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

PIHPs must select variables that identify the PIHP's 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 evaluated each PIP on 10 possible scoring elements. Collectively, the PIHPs satisfied requirements for 24 out of 27 scoring elements, for a score of 88.9 percent.

All PIHPs used performance measures that assessed an important aspect of care and were appropriate based on the availability of data and resources to collect the data. In addition, all performance measures were designed to monitor, track, and compare performance over time.

Scoring element 5.1 assessed if the variables were adequate to answer the study question. The variable for the project conducted by WM included members who received alcohol and other drug abuse (AODA) services regardless of the time from referral, but the aim statement was focused on members who received AODA services within 30 days of referral. As a result, the variables included more members than were indicated by the aim statement.

Scoring element 5.9 assessed if the measures included a strategy to ensure inter-rater reliability. One PIHP, WM, did not specify the inter-rater reliability process for manual data entry from the member records to the data collection spreadsheet. Another PIHP, CCF, did not identify the inter-rater reliability process to ensure the data manually entered by the care coordinators into the electronic care management system was entered consistently and accurately.

Observation and Analysis: Standard 6. Data Collection Procedures

PIHPs 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 evaluated each PIP on 16 possible scoring elements. Collectively, the PIHPs satisfied requirements for 36 out of 37 scoring elements, for a score of 97.3 percent.

All projects detailed data collection processes to ensure appropriate data would be available for the PIPs. Each project clearly defined the data sources and collection methods to be used. All projects except one, included details on how data obtained from the electronic care management system would be validated for completeness and accuracy.

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

PIHPs 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 evaluated each PIP on eight possible scoring elements. Collectively, the PIHPs satisfied requirements for 25 out of 36 scoring elements, for a score of 69.4 percent.

Scoring element 7.1 evaluated if the analysis was conducted in accordance with the data analysis plan. One organization, CCHP, did not implement one of the PIP projects due to staffing challenges that impacted the implementation of the PIP; therefore, it could not be determined if analysis was conducted in accordance with the data analysis plan.

Scoring element 7.2 evaluated if the analysis included baseline and repeat measurements of project outcomes. One of the aim statements for a project conducted by WM did not include a baseline rate. The organization, CCHP, did not implement one of the projects, as a result this scoring element could not be determined and was not met.

Scoring element 7.3 assessed the statistical significance of any differences between the initial and repeat measures. The organizations, CCF and WM, did not include details regarding statistical analysis of differences between the initial and repeat measures. The organization, CCHP, did not implement one of the projects, as a result this scoring element could not be determined and was not met.

Scoring element 7.6 evaluated if the PIP compared the results across multiple entities such as different patient subgroups, provider sites, or PIHPs. Children Come First did not indicate results were compared with another entity or subgroup. Chorus Community Health Plan did not implement one of the projects, as a result this scoring element could not be determined and was not met.

Scoring element 7.7 ensured report findings were presented in a concise and easily understood manner. The data presented in the WM report did not coincide with the project's study question. The organization, CCHP, did not implement one of the projects, as a result this scoring element could not be determined and was not met.

Scoring element 7.8 assessed if the analysis and interpretation of the PIP data included lessons learned about less-than-optimal performance. As CCHP did not implement one of the projects, this scoring element could not be determined and was not met.

Observation and Analysis: Standard 8. Improvement Strategies

PIHPs 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 evaluated each PIP on six possible scoring elements. Collectively, the PIHPs satisfied requirements for 20 out of 29 scoring elements, for a score of 69.0 percent.

The PIP reports designed improvement strategies to address root causes or barriers identified through data analysis and quality improvement processes. All reports included information on how the project was culturally and linguistically appropriate.

Scoring element 8.1 ensured the selected improvement strategies were evidence-based. The CCF report did not identify how the improvement strategies were selected and if there was evidence to suggest the strategies would lead to project improvement. The organization, CCHP, did not implement one of the projects, as a result this scoring element could not be determined and was not met.

Scoring element 8.3 required the PIP to utilize a Plan-Do-Study-Act (PDSA) cycle of improvement approach to test the selected improvement strategies. Children Come First did not identify any PDSA cycles of improvement were conducted during the measurement year. The organization, CCHP, did not implement one of the projects, as a result this scoring element could not be determined and was not met.

Scoring element 8.5 assessed if the implementation of the improvement strategy was designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes. The organization, CCHP, did not implement one of the projects, as a result this scoring element could not be determined and was not met.

Scoring element 8.6 evaluated if the PIP assessed the extent to which the improvement strategies were successful. The organization, CCHP, did not include details on the successfulness of the improvement strategies for one project in the PIP report. Chorus Community Health Plan did not implement its second project, and as a result this scoring element could not be determined and was not met.

The improvement strategies associated with each aim are identified below along with the effectiveness of the strategy as determined by the PIHP. The following ratings for effectiveness are applied to each strategy.

Improvement Strategy Effectiveness Ratings	
Effective	PIHP indicated strategy was effective.
Not Effective	PIHP indicated strategy was not effective.
No Evaluation	PIHP could not determine if it was effective, or there was no evaluation of the effectiveness.
Not Implemented	PIHP did not implement the strategy.

There were no state-required topics and there were no state-required improvement strategies.

PIHP	Topic	Improvement Strategies	Effectiveness
CCF	Program Transitions	Provided program recommendations to members and families following CCF disenrollment.	Effective
CCF	Program Transitions	Assisted with the referral process for newly selected program(s).	Effective
CCF	Program Transitions	Provided follow-up with members and families 30 days post disenrollment to check on the status of new program enrollment.	Effective
CCHP	Mental Health Evaluations	Manually tracked data specific to inpatient mental health hospitalizations to ensure the assigned health care coordinator was informed of due dates for follow-up assessments and care plan updates.	Effective*
CCHP	Mental Health Evaluations	Developed an auto-generated report of members with an inpatient mental health hospitalization.	Not Implemented
CCHP	Mental Health Evaluations	Developed a HEDIS® code guide to enable care management staff to determine when a mental health outpatient appointment occurred.	Effective*
CCHP	Mental Health Evaluations	Consulted with the organization's Behavioral Health Therapist during hospital admission and discharge to ensure members will receive appropriate outpatient services once they return to the community.	Effective*

PIHP	Topic	Improvement Strategies	Effectiveness
CCHP	Care Transitions	Establish an internal Care Coordination Workgroup to focus on ICHE appointment tracking and work flow to identify barriers.	Not Implemented
CCHP	Care Transitions	Conduct an assessment regarding best practice in communicating changes in provider location.	Not Implemented
WM	AODA Services	Conducted a brief AODA screen and gathered collateral information during enrollment.	Effective
WM	AODA Services	Administered a full clinical interview and assessment by the AODA Clinician using the BSTAD to youth with any positive responses to the initial screening.	Effective
WM	AODA Services	Identified risk levels and provided educational information about drug use and abuse. For youth who had been identified at higher risk, a discussion of AODA specific services for treatment and intervention took place and an AODA provider referral was completed.	Effective
WM	Literacy	Screen youth at enrollment for literacy.	Effective
WM	Literacy	Provide face to face phonics instruction once a week for 16 hours.	Effective

**Effectiveness of the improvement strategy was identified during the interview, but was not included in the PIP report*.

Observation and Analysis: Standard 9. Significant and Sustained Improvement

An important component of a PIP is to demonstrate sustained improvement. The PIHPs 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 PIHPs satisfied requirements for seven out of 14 scoring elements, for a score of 50.0 percent.

Scoring element 9.1 evaluated if the same methodology was used for the project's baseline and repeat measurements. Wraparound Milwaukee did not calculate the initial and repeat measures using the same methodology for the inclusion criteria for the PIP population. One of the CCHP projects included a baseline measure; however, the methodology used to establish the baseline was not identified. The organization, CCHP, did not implement one of the projects, as a result this scoring element could not be determined and was not met.

Scoring element 9.2 evaluated if there was quantitative evidence of improvement. One of WM's projects did not demonstrate improvement for the second aim statement. The other project conducted by WM did not calculate the initial and repeat measures using the same methodology; therefore, the reported improvement was not accurate. The organization, CCHP,

did not implement one of the projects, as a result this scoring element could not be determined and was not met.

Scoring element 9.4 evaluated if there was statistical evidence that any observed improvement was the result of the interventions. Children Come First's PIP report did not evidence the use of a statistical test to measure the change in rates between the baseline and repeat measures.

Significant Improvement

The significant improvement rating was determined by MetaStar through the use of a statistical test using the project's baseline and repeat measurement for the aim statement. If there are multiple aim statements, testing is completed on each aim and the lowest rating achieved is the significant improvement rating for the project. Data used by the PIHP to determine baseline and repeat measurements was submitted to MetaStar for the evaluation. The results for each non-clinical aim are outlined below.

PIHP	Topic	Baseline Measurement	Repeat Measurement	Significant Improvement Rating
CCF	Program Transitions	14 members that enrolled in another DCDHS program, such as CCS or CLTS/40 members that disenrolled from CCF	54 members that enrolled in another DCDHS program, such as CCS or CLTS/90 members that disenrolled from CCF	Low Confidence
CCHP	Mental Health Evaluations	Baseline provided was not based on the data from the HEDIS® measurement.	17 children with a follow up visit within 30 days of discharge/30 children with an inpatient hospitalization for mental health reasons	No Confidence
CCHP	Care Transitions	70 non-timely ICHEs completed related to access to care barriers/151 non-timely ICHEs completed	The project was not implemented; therefore, no repeat measurement was obtained as a result of the project.	No Confidence
WM	AODA Services	7 youth who received AODA services within 30 days of referral/28 youth assessed as high-risk for AODA use	8 youth who received AODA services/27 youth assessed as high-risk for AODA use	Low Confidence
WM Aim A	Literacy	The total average Accuracy and Words Correct per Minute outcome baseline score minus the total average Accuracy and Words Correct per Minute outcome after Phase I instruction/The total average Accuracy and Words Correct per Minute outcome baseline score	The total average Accuracy and Words Correct per Minute outcome baseline score minus the total average Accuracy and Words Correct per Minute outcome after Phase I instruction/The total average Accuracy and Words Correct per Minute outcome baseline score	No Confidence

PIHP	Topic	Baseline Measurement	Repeat Measurement	Significant Improvement Rating
WM Aim B	Literacy	The total average Accuracy and Words Correct per Minute outcome Phase I score minus the total average Accuracy and Words Correct per Minute outcome after Phase II instruction/The total average Accuracy and Words Correct per Minute outcome Phase 1 score.	The total average Accuracy and Words Correct per Minute outcome Phase I score minus the total average Accuracy and Words Correct per Minute outcome after Phase II instruction/The total average Accuracy and Words Correct per Minute outcome Phase 1 score.	No Confidence

** Significant improvement could not be determined due to a different methodology used for the baseline and repeat measurement.*

Progress on Previous EQRO Plan Level Recommendations

MetaStar assessed the degree that each MCO effectively addressed recommendations for quality improvement made by the EQRO during the previous year's EQR. The following rating scale was applied to each MCO.

Degree to Which the MCO Addressed the Recommendations	
High	The MCO addressed all recommendations.
Medium	The MCO addressed more than half of the recommendations, but not all.
Low	The MCO addressed less than half of the recommendations.

The following table identifies the recommendations made the by the EQRO in the prior review, CY 2023, the actions taken by the MCO to address the recommendations, and the degree to which the MCO addressed the recommendations.

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Anthem	– Include evidence of statistical analysis to assess differences between the initial and repeat measurements. – Present results that are easily understood and relate to the aim statement. – Include statistical evidence that observed improvement is the result of the interventions.	– The organization included evidence of statistical analysis to assess differences between the initial and repeat measurements. – The organization presented results that were easily understood and related to the aim statement.	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCHP	– Include a list of data collection personnel and relevant qualifications for staff collecting data from the medical record review. – Conducted an inter-rater and intra-rater reliability process for personnel collecting data from the medical record review. – Ensure project results are compared across other entities, such as different organizations or sub-groups. – Present results in a concise and easily understood manner. – Design a strategy that identifies potential project barriers and the plan to address those barriers. – Ensure a Plan-Do-Study-Act approach is used to test the improvement strategies. – Continue to build methodologically sound performance improvement projects to ensure quantitative improvement is demonstrated from baseline to repeat rates. – Continue to build methodologically sound performance improvement projects to ensure project results demonstrate an improvement from the baseline rate each year of a continuing project.	– The organization included a list of data collection personnel and relevant qualifications for staff collecting data from the medical record review. – The organization conducted an inter-rater and intra-rater reliability process for personnel collecting data from the medical record review. – The organization ensured project results were compared across other entities, such as different organizations or sub-groups. – The PIP results were presented in a concise and easily understood manner. – The strategy was designed to identify potential project barriers and a plan to address those barriers. – The organization implemented a Plan-Do-Study-Act approach that was used to test the improvement strategies.	Medium
CCHP (FCMH)	– Ensure the aim statement clearly specifies the improvement strategies for the project. – Include all required criteria in the aim statement, ensuring it is answerable. – Specify the frequency of data collection for all project measures. – Establish and clearly document the data analysis plan to ensure that appropriate data will be available for the project.	– The organization ensured the aim statement clearly specified the improvement strategies for the project. – The aim statement included all required criteria, ensuring it was answerable. – The organization specified the frequency of data collection for all project measures. – The data analysis plan was established and clearly documented to ensure that	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Ensure a data analysis plan is outlined in the report. – Include evidence of statistical analysis to assess differences between the initial and repeat measurements. – Perform and document an analysis comparing the results to other entities or population subgroups. – Use a rapid-cycle Plan-Do-Study-Act approach to test the selected improvement strategies during the project. – Use data analysis and interpretation to assess the extent to which the improvement strategies were successful and identify potential follow-up activities. – Conduct statistical testing to determine if project improvement is the result of the interventions.	appropriate data would be available for the project.	
DHP	– Ensure sustained improvement is demonstrated through repeated measurements over time for continuing projects.	– No progress was identified in the validation of the projects, and recommendations from the prior review were not successfully addressed in each project submitted.	Low
GHC-EC	– 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.	– Statistical evidence that the observed improvement was the result of the intervention was documented in the report.	Medium
GHC-SCW	– Include the qualifications of staff conducting medical record reviews in the project's report. – Conduct statistical testing on the project's baseline and repeat measurements to determine statistical significance. – Conduct statistical testing on the project's baseline and repeat measurements to determine statistical significance.	– The organization included the qualifications of staff conducting medical record reviews in the project's report. – The organization conducted statistical testing on the project's baseline and repeat measurements to determine statistical significance.	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Design methodologically sound performance improvement projects to demonstrate improvement from baseline to remeasurement. – Include statistical evidence that observed improvement is the result of the interventions.	– The organization designed a methodologically sound performance improvement project to demonstrate improvement from baseline to remeasurement. – The organization included statistical evidence that observed improvement is the result of the interventions.	
*i*Care	– Analyze data according to the data analysis plan or explain any deviation from the plan when warranted. – Include evidence of statistical analysis to assess differences between the initial and repeat measurements in future projects. – Ensure PIP findings are presented in an easily understood manner. – Document a continuous cycle of improvement used to test a selected improvement strategy. – Continue to design a methodologically sound performance improvement project to demonstrate improvement from baseline to remeasurement. – Focus efforts on improving results of repeat measurements each year of the project.	– The organization analyzed the data according to the data analysis plan and explained any deviation from the plan when warranted. – The organization documented a continuous cycle of improvement used to test the selected improvement strategy	Low
MCHP	– Include an analysis of the baseline and repeat measures identified in the project aim statement. – Include evidence of statistical analysis to assess differences between initial and repeat measures. – Ensure results are clear and easily understood in future projects. – Include lessons learned or opportunities for improvement based on the data analysis when the aim is not achieved.	– The organization included lessons learned or opportunities for improvement based on the data analysis when the aim was not achieved.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Assess the success of improvement strategies and identify potential follow-up activities. – Continue to build methodologically sound performance improvement projects to demonstrate improvement from baseline to remeasurement. – Include statistical evidence to determine if improvement is due to interventions in future projects. – Continue to build a methodologically sound project to increase the probability of sustained improvement for projects spanning multiple years.		
MHS	– Detail the inter-rater and intra-rater reliability process for organizational staff conducting medical record review. – Document a continuous cycle of improvement used to test a selected improvement strategy.	– The organization detailed the inter-rater and intra-rater reliability process for organizational staff conducting medical record review. – The organization documented a continuous cycle of improvement used to test a selected improvement strategy	High
MHWI	– Focus efforts on improving results of repeat measures each year of a continuing project.	– No progress was identified in the validation of the projects, and recommendations from the prior review were not successfully addressed in each project submitted.	Low
MCW	– Ensure aim statements are concise. – Report the PIP results in a concise and easily understood manner. – Develop methodologically sound performance improvement projects to ensure results have quantitative evidence of improvement from the baseline rates that are sustained through repeated measurements.	– The organization ensured the aim statements were concise. – The organization reported the PIP results in a concise and easily understood manner. – The organization developed methodologically sound performance improvement projects to ensure results had quantitative evidence of improvement from the baseline rates that were sustained through repeated measurements.	High

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
NHP	– Ensure the goal identified for the project is an improvement over the rate obtained during the previous measurement year. – Detail the inter-rater and intra-rater reliability process for organizational staff conducting medical record review. – Review documentation within the report to ensure the project's results and findings are presented in a concise and easily understood manner. – Detail lessons learned about less-than-optimal performance when rates decline from year to year. – Document a continuous cycle of improvement used to test a selected improvement strategy. – Design a methodologically sound performance improvement project to ensure project results demonstrate an improvement from the baseline rate identified in the project's aim statement. – Focus efforts on improving results of repeat measurements each year of the project.	– The organization detailed the inter-rater and intra-rater reliability process for organizational staff conducting medical record review. – The organization documented a continuous cycle of improvement used to test a selected improvement strategy. – The organization designed a methodologically sound performance improvement project to ensure project results demonstrated an improvement from the baseline rate identified in the project's aim statement.	Low
Quartz	– Ensure the aim statement is concise. – Ensure the aim statement is measurable by identifying a baseline measurement. – Ensure the project has a baseline measure identified in the report in order to analyze baseline and repeat measurements of project outcomes. – Include evidence of statistical testing to assess differences between the initial and repeat measurements. – For projects that have less-than-optimal performance, ensure the report includes lessons learned in the analysis of the PIP data. – Explain the rationale for the selected improvement strategies,	– The organization ensured the aim statement was concise. – The organization specified the frequency of data collection in the project design. – The organization included a data collection plan that linked to the data analysis plan. – The organization included a baseline measure to be able to analyze baseline and repeat measurements of project outcomes. – The organization included lessons learned in the analysis of the data for projects that had less than optimal performance. – The organization demonstrated improvement strategies were evidence-based.	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	including how the strategies are evidence-based. – Complete and document all stages of a rapid-cycle Plan-Do-Study-Act approach in the projects. – Continue to build methodologically sound performance improvement projects to ensure project results demonstrate an improvement from the baseline rates for projects. – Focus efforts on improving results to gain quantitative evidence of improvement through repeated measurements each year of a continuing project.	– The organization completed and documented all stages of a rapid-cycle-Plan-Do-Study-Act approach in the reports.	
SHP	– Include the project's improvement strategy in the aim statement. – Ensure aim statements are answerable by including all required elements. – Develop measurable aim statements by including a baseline measure for each aim. – Ensure the data collection plan is linked to the data analysis plan. – Ensure data analysis is conducted in accordance with the data analysis plan. – Ensure analysis includes baseline and repeat measures for each aim statement. – Include evidence of statistical analysis to assess differences between initial and repeat measures. – Account for any factors that may influence the comparability of baseline and remeasurement. – Ensure final project results are concise and easily understood. – Ensure improvement strategies are evidence based. – Design a strategy that accounts or adjusts for barriers that may impact project outcomes.	– The organization developed measurable aim statements by including a baseline measure for each aim. – The organization ensured the data collection plan was linked to the data analysis plan. – The organization ensured data analysis was conducted in accordance with the data analysis plan. – The organization ensured analysis included baseline and repeat measures for each aim statement. – The organization included evidence of statistical analysis to assess differences between initial and repeat measures. – The organization ensured final project results were concise and easily understood. – The organization ensured improvement strategies were evidence based. – The organization designed strategies that accounted or adjusted for barriers that may have impacted project outcomes.	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Utilize a Plan-Do-Study-Act approach to test the selected improvement strategies. – Incorporate cultural and linguistic considerations in improvement strategies. – Develop a plan to address variables encountered during the project. – Using data analysis and interpretation, assess the extent to which the improvement strategies were successful. – Ensure the same methodology is used for baseline and repeat measurements. – Continue to develop methodologically sound projects to demonstrate quantitative evidence of improvement. Focus efforts on improving results of repeat measurements each year of a continuing project.	– The organization incorporated cultural and linguistic considerations in improvement strategies. – The organization developed a plan to address variables encountered during the project. – The organization assessed the extent to which the improvement strategies were successful. – The organization ensured the same methodology was used for baseline and repeat measures.	
UHC	– Focus efforts on improving results to gain quantitative evidence of improvement through repeated measurements each year of a continuing project.	– No progress was identified in the validation of the projects, and recommendations from the prior review were not successfully addressed in each project submitted.	Low
CCF	– Identify an improvement strategy as part of the aim statement. – Ensure the aim statement clearly specifies the project's start and end measurement period. – Ensure the aim statement is answerable by including all required components. – Include baseline rates along with the goals for improvement in the aim statement. – Design performance measures to monitor, track, and compare performance over the course of the project timeframe. – Describe and implement an inter-rater reliability process for manual data entry.	– The organization provided an aim statement that comprised all required elements including the project's improvement strategy, measurement period, baseline rate, and goal for improvement. – The organization designed performance measures that monitored, tracked, and compared performance over the course of the project. – The organization analyzed the impact of the project's interventions. – The organization conducted a project that demonstrated improvement from baseline to repeat measurement.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Design performance measures to monitor, track, and compare performance over the course of the project timeframe. – Describe and implement an inter-rater reliability process for manual data entry. – Include a rapid-cycle Plan-Do-Study-Act approach to evaluate improvement strategies. – Identify variables that may influence the outcome of the project, and ensure strategies are designed to address the identified variables. – Analyze the impact of the interventions on the project and identify follow-up activities based on the analysis of the strategies. – Build a methodologically sound performance improvement project to ensure project results demonstrate an improvement from the baseline rates for each component of the study question or aim statement.		
WM	– Clearly specify the correct time period for the PIP in each aim statement. – Ensure each aim statement is answerable by including accurate criteria for the aim. – Ensure the project includes a strategy for inter-rater reliability for manual data collection. – Provide a description of how data collection from the electronic health record validates the collected data is accurate and complete. – Assess statistical significance between the initial and repeat measures with an established baseline. – Compare multiple entities within the project, such as member subgroups of race, gender, and/or zip code.	– No progress was identified in the validation of the projects, and recommendations from the prior review were not successfully addressed in each project submitted.	Low

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 Measures*. The review assesses the accuracy of performance measures reported by the Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plan (PIHP), and determines the extent to which performance measures calculated by the MCOs and PIHP follow state specifications and reporting requirements. Assessment of an MCO's and PIHP's information system is required as part of performance measures validation (PMV) and other mandatory review activities. To meet this requirement, each MCO and PIHP receives an Information Systems Capabilities Assessment (ISCA) once every three years as directed by the Wisconsin Department of Health Services (DHS), or reports compliance with the ISCA through the MCO's Healthcare Effectiveness Data and Information Set (HEDIS®)[3] audit results. The ISCAs and verification of the MCO's HEDIS® audit results are conducted and reported separately.

The MCO quality indicators for Calendar Year (CY) 2023, reported in CY 2024, are set forth in the annual *Wisconsin Department of Health Services (DHS) Division of Medicaid Services (DMS) HMO Quality Guide Measurement Year (MY2023)* for the Supplemental Security Income (SSI) and BadgerCare Plus (BC+) programs, and in the *Wisconsin Department of Health Services Division of Medicaid Services Foster Care Medical Home Quality Guide Measurement Year 2023* for the Foster Care Medical Home (FCMH) program. 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 organization. DHS has established pay for performance (P4P) incentives as a performance improvement strategy for SSI and BC+ MCOs, to improve priority HEDIS® scores. This strategy is a key component of the *Division of Medicaid Services Medicaid Managed Care Strategy*. The strategy links the mandatory *EQR Protocol 2: Validation of Performance Measures Reported by the MCO* review described in this report with some of the PMV requirements for MCOs.

Validation of performance measures was conducted for the following organizations:

Organizations	Program(s)
Anthem Blue Cross and Blue Shield Health Plan (Anthem)	BC+ SSI
Chorus Community Health Plan, Inc. (CCHP)	BC+ FCMH

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

Organizations	Program(s)
Dean Health Plan, Inc. (DHP)	BC+
Group Health Cooperative of Eau Claire (GHC-EC)	BC+ SSI
Group Health Cooperative of South-Central Wisconsin (GHC-SCW)	BC+
Independent Care Health Plan (*i*Care)	BC+ SSI
MercyCare Health Plans (MCHP)	BC+
MHS Health Wisconsin (MHS)	BC+ SSI
Molina HealthCare of Wisconsin (MHWI)	BC+ SSI
My Choice Wisconsin, Inc. (MCW)	BC+ SSI
Network Health Plan (NHP)	BC+ SSI
Quartz Health Solutions, Inc. (Quartz)	BC+ SSI
Security Health Plan of Wisconsin, Inc. (SHP)	BC+ SSI
United Healthcare Community Plan (UHC)	BC+ SSI

BadgerCare Plus and Supplemental Security Income

DHS has identified 10 performance measures for the BC+ program and seven for the SSI program in CY 2023. The measures focus on access to care, preventative services, maternal health, chronic disease management, and behavior health outcomes.

According to 42 CFR §438.360, states have the option to utilize results from a private accreditation review to avoid duplication if the requirements are comparable to standards identified in the EQR protocols and 42 CFR §438.358. The performance measures identified by DHS are NCQA HEDIS® measures, which are standardized performance measures developed by NCQA and used to objectively measure, report and compare quality across health plans, and are validated by a certified NCQA HEDIS® auditor. MetaStar did not validate the measures but performed an analysis of the reported results.

The state rates for all measures were calculated using the guidance found with the *Centers for Medicare & Medicaid Services – Medicaid & CHIP Health Care Quality Measures Technical Assistance Resource* for calculating state-level rates using data from multiple reporting units. Methods to calculate rates for administrative, hybrid, and a combination of the two were utilized and completed by DHS.

Results

MetaStar compared the State's performance on national HEDIS® measures with national benchmarks published annually by NCQA in the *Quality Compass®*[4] report with the permission of NCQA. These benchmarks represent performance of NCQA-accredited Medicaid managed care plans and Medicaid managed care plans that are either required to report HEDIS® measures by the state agency responsible for monitoring managed Medicaid performance or opt to publicly report their HEDIS® rates. The HEDIS® measures reported to NCQA vary by plan. These national benchmarks reflect the average of the plans that reported the benchmark and are not a true national average of all Medicaid managed care plans. Also, note these plans represent states with and without Medicaid expansion coverage.

HEDIS® Measurement Year 2023 Volume 2: Technical Specifications for Health Plans, issued by NCQA was utilized for the analysis. HEDIS® rates are reported by Measurement Year (MY), which aligns with the calendar year. For this activity, MY will be used when discussing HEDIS® rates to align with the technical specifications. MY 2023 HEDIS® rates were reported in CY 2024 and were reviewed and analyzed for this activity.

The licensing agreement with NCQA limits the number of benchmarks that can be published each year. The current agreement limits publication to two benchmarks for 15 measures. A licensing agreement exists for both MY 2022 and MY 2023. The two benchmarks selected are the national 50th percentile and the national 75th percentile.

Scoring Legend	
National Benchmark	**Result**
Above 75th Percentile	Strength
75th - 50th Percentile	Compliant
Below 50th Percentile	Opportunity

The MY 2023 rates are compared to the 50th and 75th percentile national benchmarks from MY 2023 by measure. The following tables identify statewide rates compared to the 50th and 75th percentile benchmarks by measure for MY 2023.

[4] Quality Compass® is a registered trademark of NCQA.

BadgerCare Plus	State Rate	50th Percentile	75th Percentile	Results
Children's Health - Primary Care Access and Preventative Care				
BC+ Childhood Immunization Status - Combo 3 (CIS)	62.0%	64.0%	68.9%	Opportunity
BC+ Immunizations for Adolescents - Combo 2 (IMA)	36.0%	34.3%	40.9%	Compliant
BC+ Lead Screening in Children (LSC)	67.9%	62.8%	70.1%	Compliant
BC+ Child and Adolescent Well-Care Visits (Total) (WCV)	50.2%	48.1%	55.1%	Compliant
Maternal Health				
BC+ Prenatal and Postpartum Care - Timeliness of Prenatal Care (PPC)	87.8%	84.2%	88.3%	Compliant
BC+ Prenatal and Postpartum Care - Postpartum Care (PPC)	82.1%	78.1%	82.0%	Strength
Disease Management – Chronic Conditions				
BC+ Asthma Medication Ratio (Total) (AMR)	65.7%	65.6%	70.8%	Compliant
BC+ Hemoglobin A1c Control for Patients with Diabetes (HBD)	56.6%	52.3%	57.2%	Compliant
BC+ Controlling Blood Pressure (CBP)	66.7%	61.3%	67.3%	Compliant
Disease Management – Behavioral Health				
BC+ Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total (FUH)	62.9%	57.7%	65.4%	Compliant

SSI	State Rate	50th Percentile	75th Percentile	Results
Chronic Conditions				
SSI Asthma Medication Ratio (Ages 19-64) (AMR)	62.8%	65.6%*	70.8%*	Opportunity
Hemoglobin A1c Control for Patients with Diabetes (HBD)	60.4%	52.3%	57.2%	Strength
Behavioral Health				
SSI Follow-Up After Hospitalization for Mental Illness - 30 Days (Total) (FUH)	61.3%	57.7%	65.4%	Compliant
SSI Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total) (FUM)	54.0%	54.9%	64.3%	Opportunity
SSI Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	80.4%	79.1%	82.3%	Compliant

SSI	State Rate	50th Percentile	75th Percentile	Results
Preventative Health				
SSI Breast Cancer Screening (BCS-E)	53.6%	52.6%	57.5%	Compliant
SSI Cervical Cancer Screening (CCS)	58.0%	57.1%	61.8%	Compliant

**NCQA Benchmark rates for AMR is from total measurement, which includes ages 5 – 65.*

The results for each measure reported by each MCO compared to the statewide aggregate and national benchmarks of the 50th percentile and 75th percentile are summarized below. Several measures are continuing measures from DHS' CY 2022 quality guide and some are new measures in DHS' CY 2023 quality guide. For continuing measures, MCO data from CY 2022 is included for comparison. For new measures, only the CY 2023 results will be displayed. See Appendix 4 for individual MCO rates.

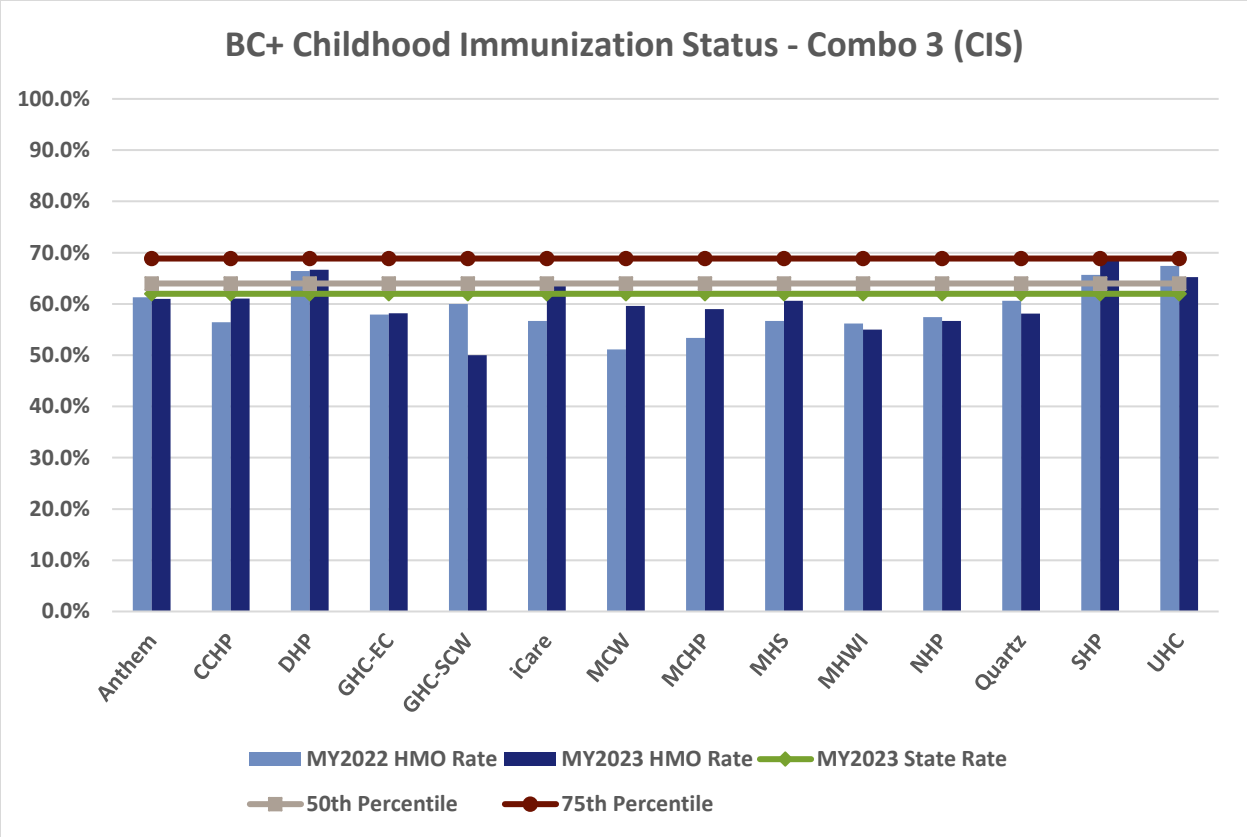
BC+ Children's Health – Primary Care Access and Preventative Care

Promoting child health is essential to a child's overall well-being and development. Child health prevention and screening measures relate to whether enrollees receive adequate preventive care needed to prevent chronic conditions or other acute health problems. These measures reflect access and quality.

Childhood Immunization Status (Combo 3) (CIS)

The graph below displays the results for *Childhood Immunization Status (Combo 3) (CIS)*. This measure is the percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday.

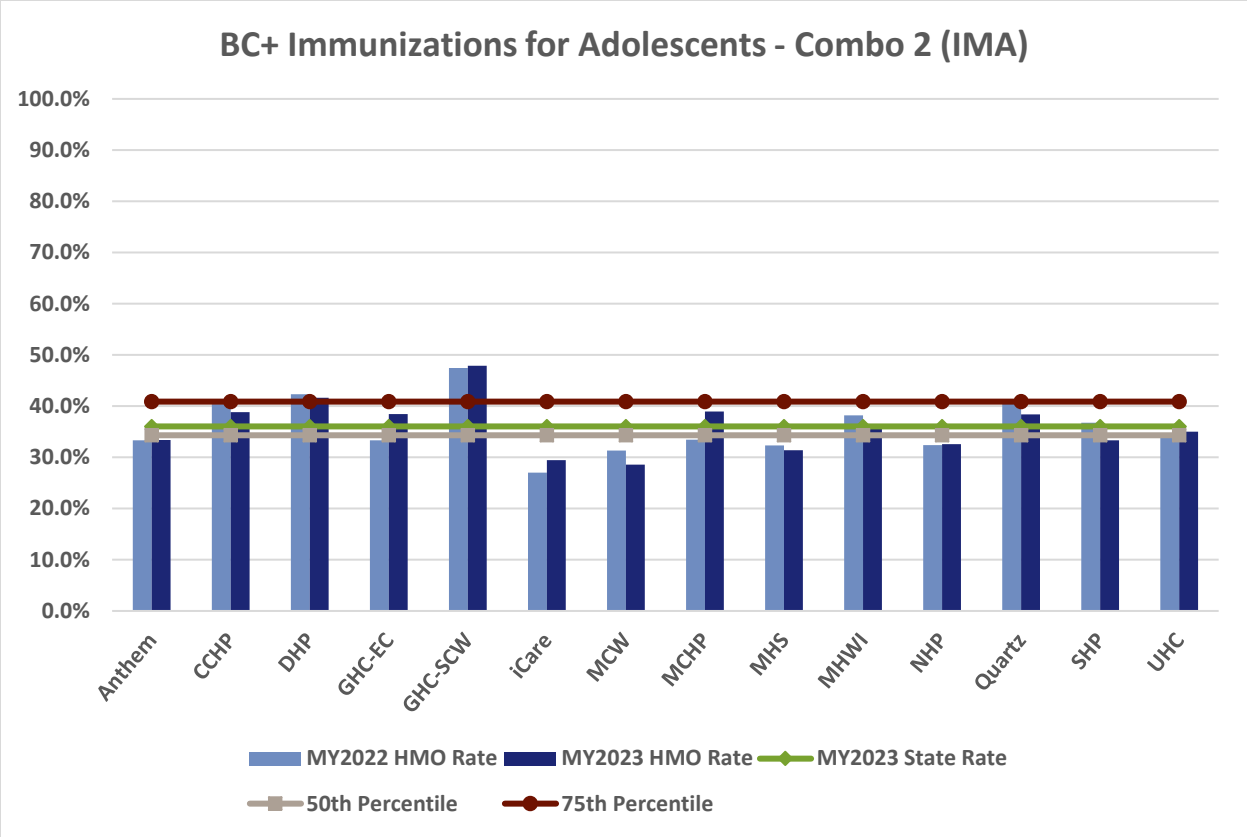
Results for the measure indicated opportunities for improvement in related practices.



Immunizations for Adolescents (Combo 2) (IMA)

The graph below displays the results for *Immunizations for Adolescents (Combo 2) (IMA)*. This measure is the percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) by their 13th birthday.

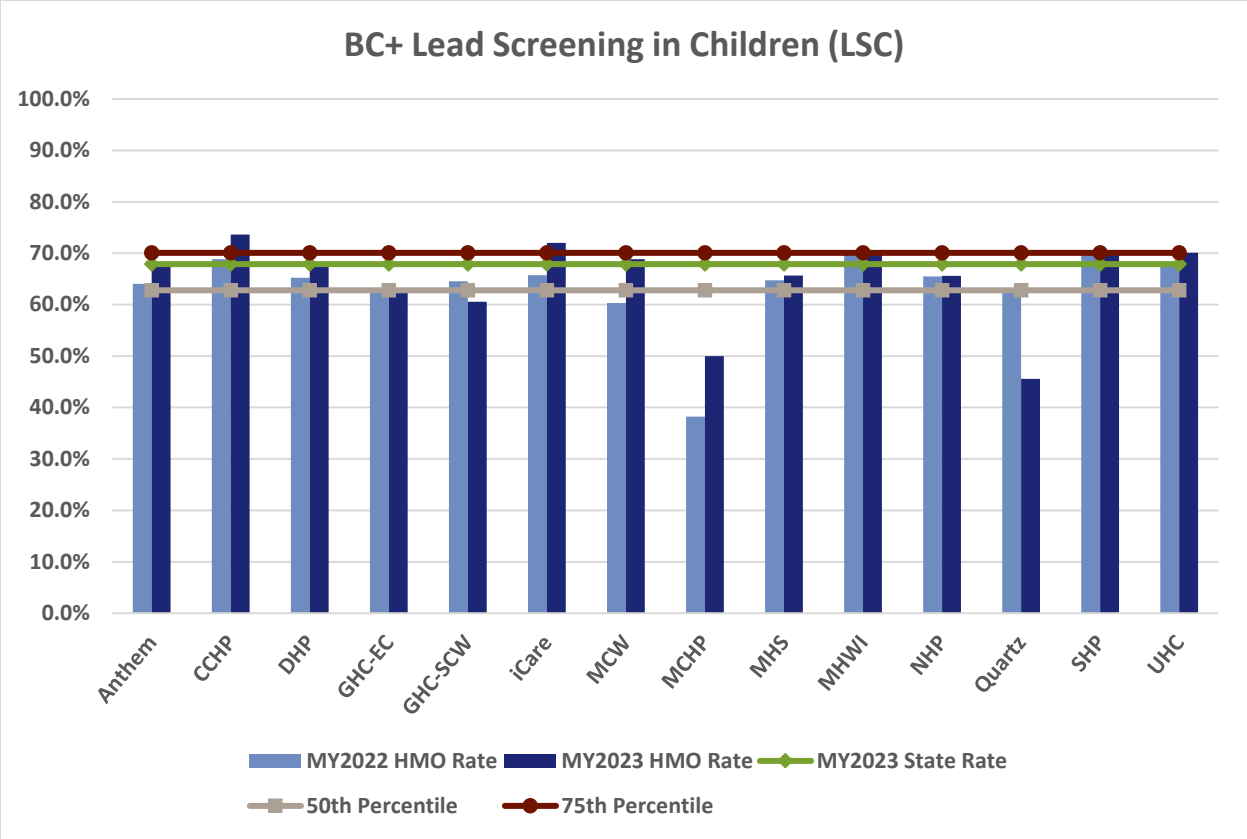
Results for the measure indicated compliant practices.



Lead Screening in Children (LSC)

The graph below displays the results for *Lead Screening in Children (LSC)*. This measure is the percentage of children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

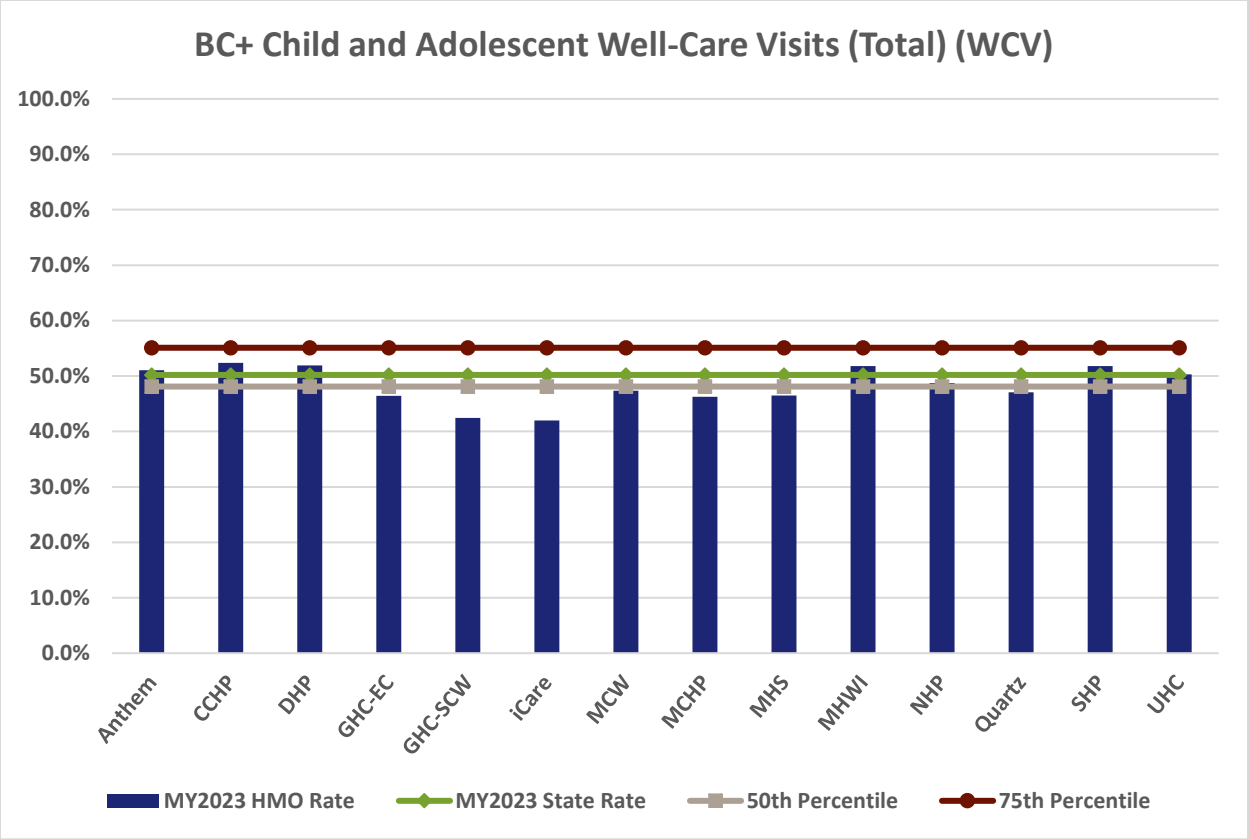
Results for the measure indicated compliant practices.



Child and Adolescent Well-Care Visits (Total) (WCV)

The graph below displays the results for *Child and Adolescent Well-Care Visits (Total) (WCV)*. This measure is the percentage of members ages three-21 years old who had at least one comprehensive well-care visit with a primary care physician or an obstetrics and gynecology practitioner during the measurement year. This measure was a new performance measure in CY 2023; therefore, there are no prior years for comparison.

Results for the measure indicated compliant practices.



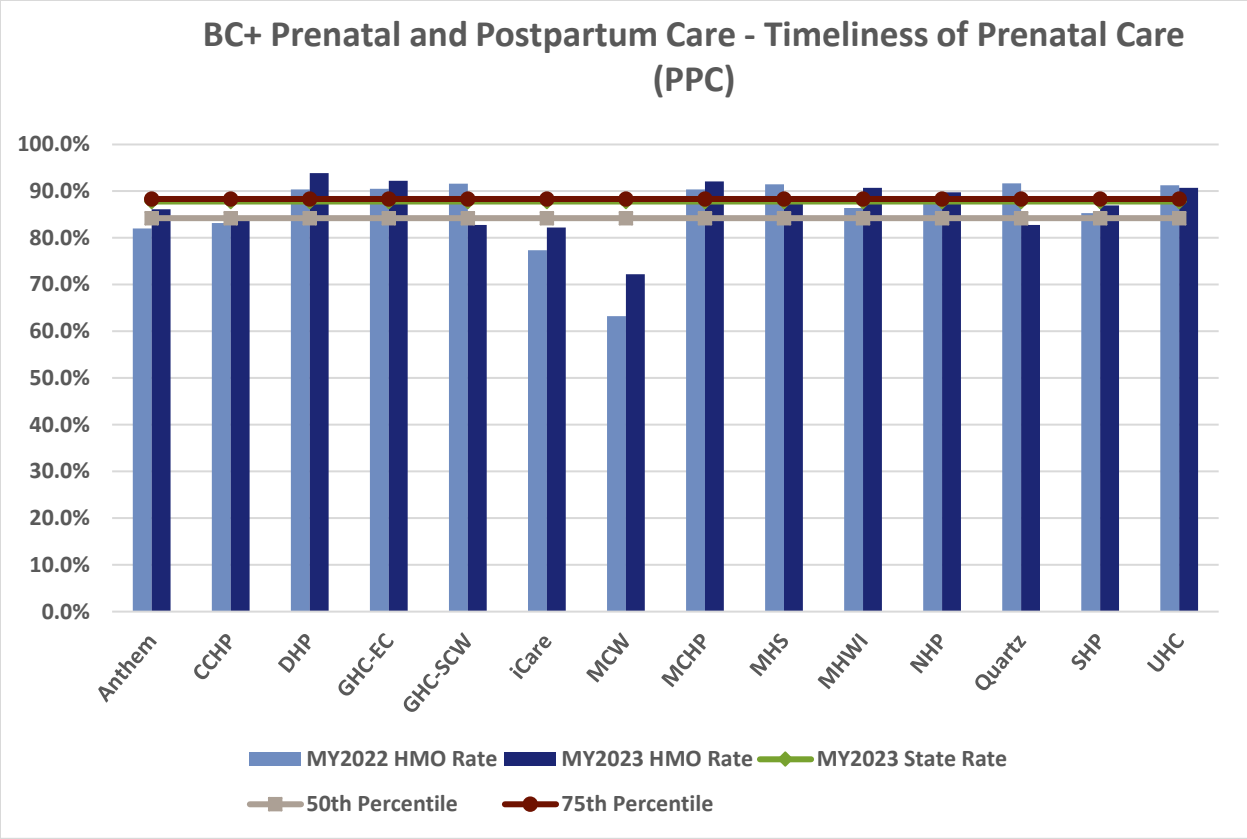
BC+ Maternal Health

Maternal health includes measures related to adequate prenatal and postpartum care, which are essential for positive pregnancy outcomes. These measures reflect access and quality.

Timeliness of Prenatal Care (PPC)

The graph below displays the results for *Timeliness of Prenatal Care (PPC)*. This measure is the percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.

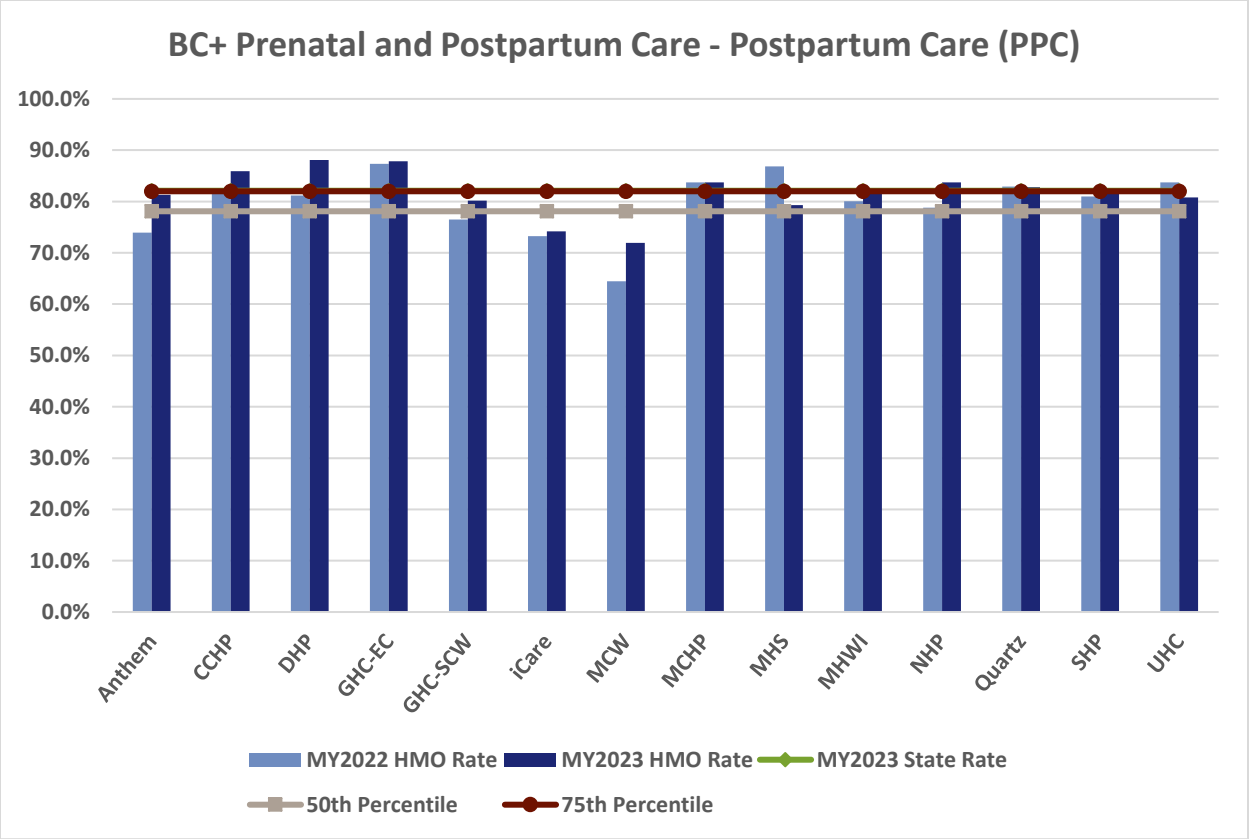
Results for the measure indicated compliant practices.



Postpartum Care (PPC)

The graph below displays the results for *Postpartum Care (PPC)*. This measure is the percentage of deliveries that had a postpartum visit on or between seven and 84 days after a live birth.

Results for the measure indicated strengths in related practices.



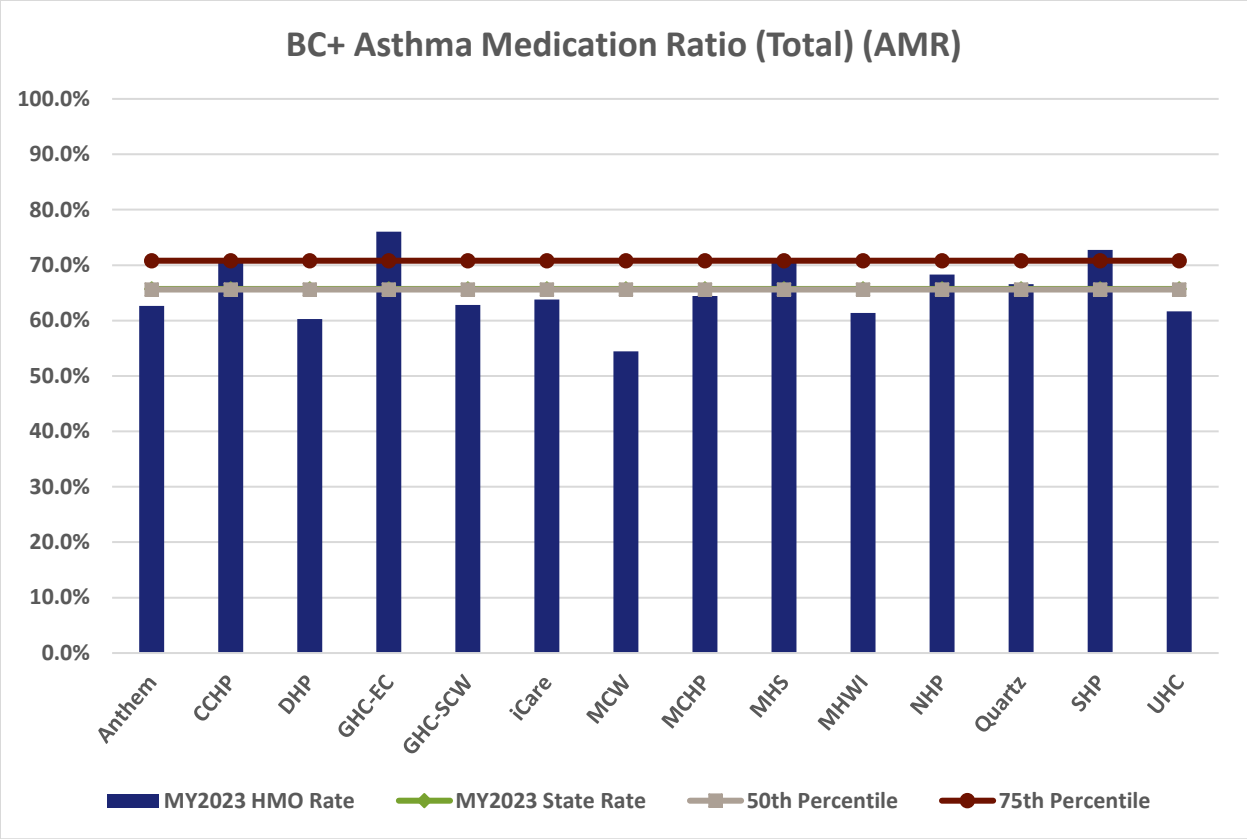
BC+ Disease Management – Chronic Conditions

Disease management measures relate to whether enrollees with chronic conditions receive adequate outpatient management services to prevent worsening of chronic conditions and more costly inpatient and emergency department services. These measures reflect access and quality.

Asthma Medication Ratio (Total) (AMR)

The graph below displays the results for *Asthma Medication Ratio (Total) (AMR)*. This measure is the percentage of members five-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. This measure was a new performance measure in CY 2023; therefore, there are no prior years for comparison.

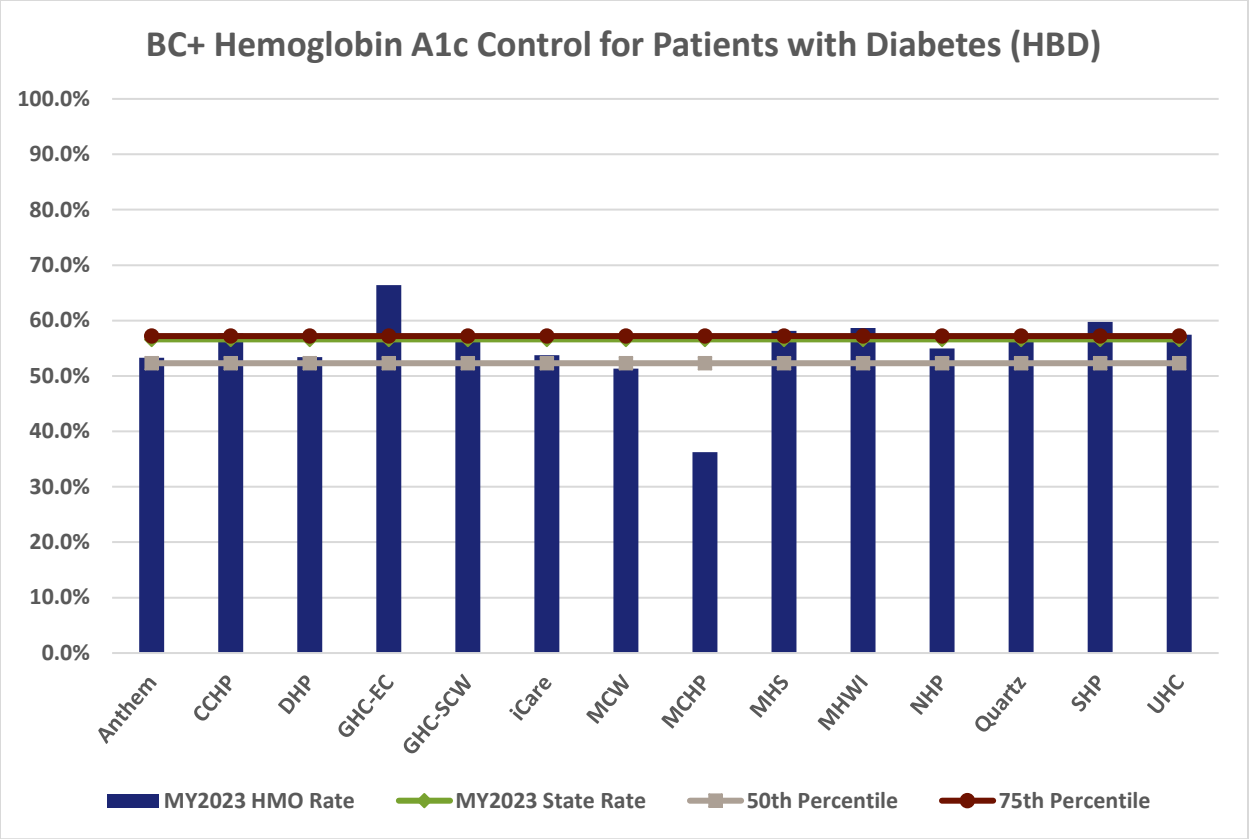
Results for the measure indicated compliant practices.



Hemoglobin A1c Control for Patients with Diabetes (HBD)

The graph below displays the results for *Control for Patients with Diabetes (HBD)*. This measure is the percentage of members 18–75 years of age with diabetes (Type 1 and Type 2) who had HbA1c Control (<8.0%). This measure was a new performance measure in CY 2023; therefore, there are no prior years for comparison.

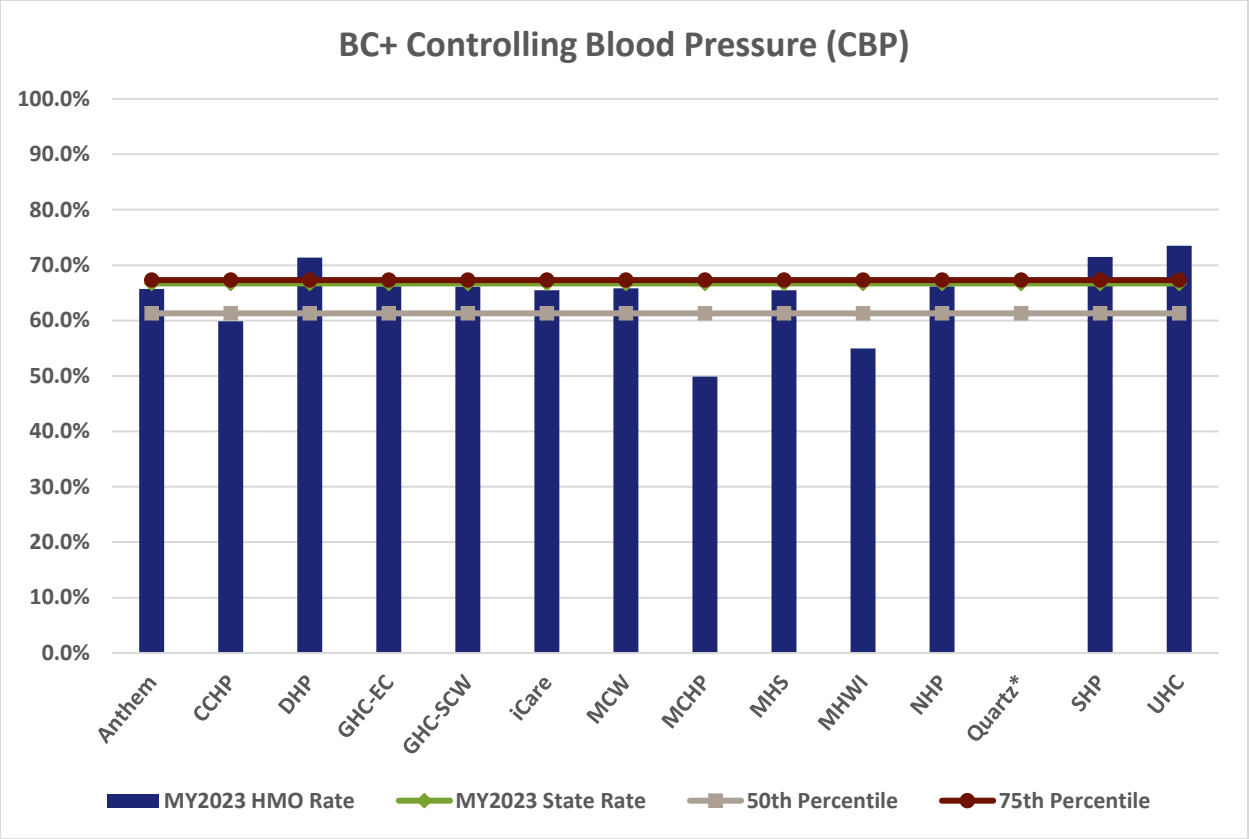
Results for the measure indicated compliant practices.



Controlling Blood Pressure (CBP)

The graph below displays the results for *Controlling Blood Pressure (CBP)*. This measure is the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled. This measure was a new performance measure in CY 2023; therefore, there are no prior years for comparison.

Results for the measure indicated compliant practices.



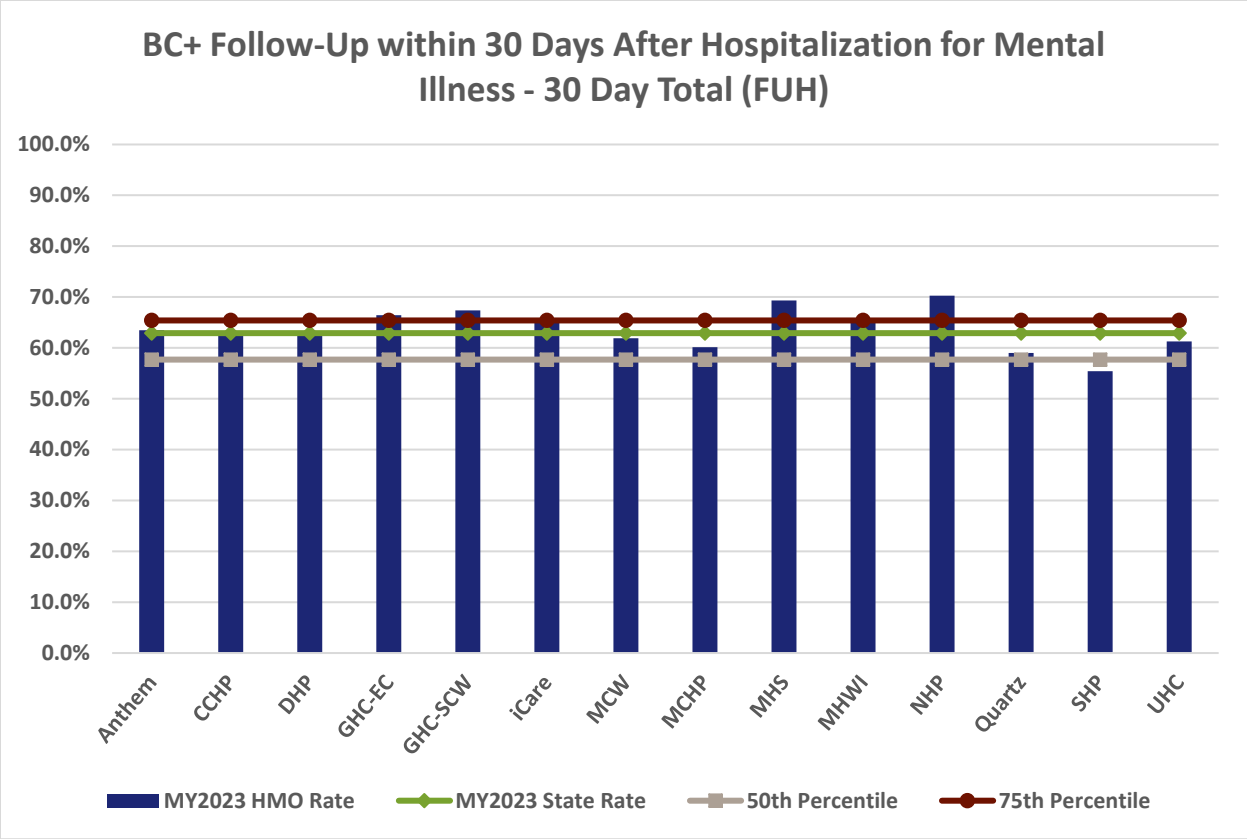
BC+ Disease Management – Behavioral Health

Improving the management of behavioral health involves comprehensive strategies to enhance care, support, and outcomes for individuals facing mental health conditions. The measure for timely follow-up after hospitalization for mental illness ensures that enrollees who have been hospitalized due to a mental health issue receive adequate follow-up in an outpatient setting. This measure reflects timeliness, access, and quality.

Follow-Up After Hospitalization for Mental Illness - 30 Days (Total) (FUH)

The graph below displays the results for *Follow-Up After Hospitalization for Mental Illness 30 Days (Total) (FUH)*. This measure is the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. This measure was a new performance measure in CY 2023; therefore, there are no prior years for comparison.

Results for the measure indicated compliant practices.



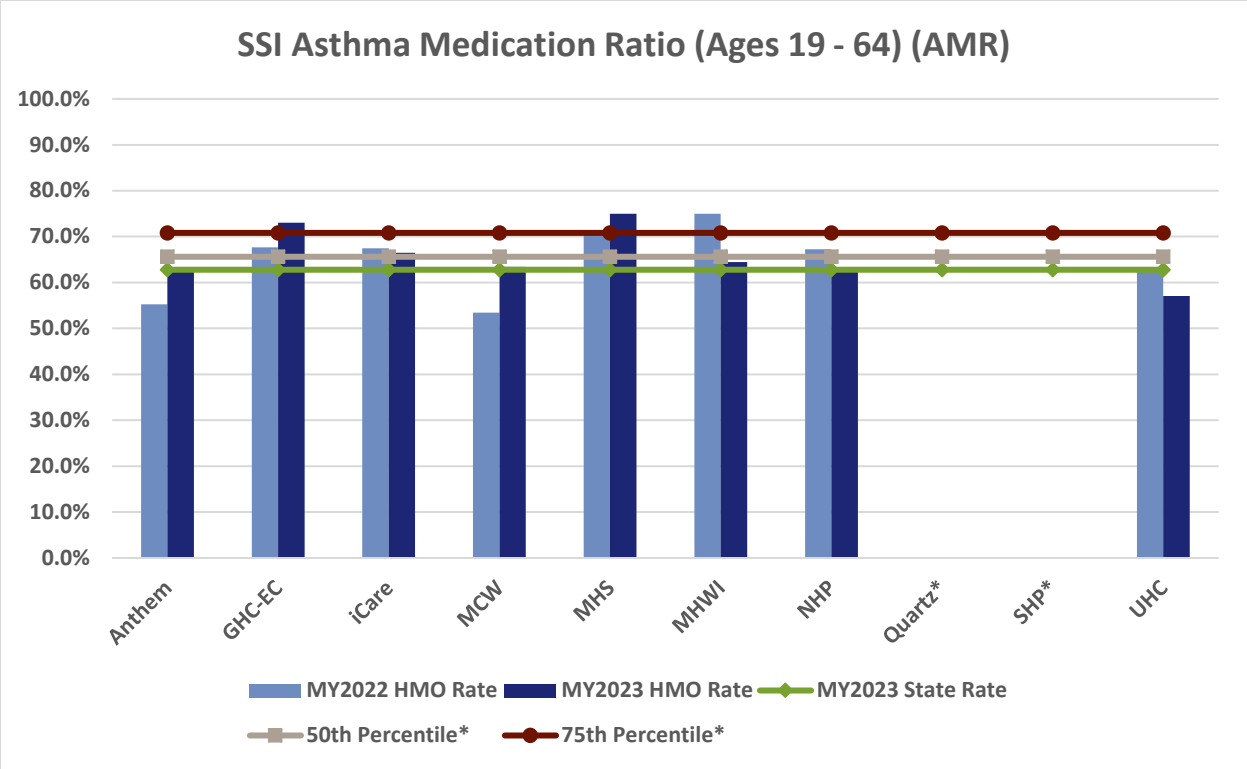
SSI Chronic Conditions

Chronic disease management measures relate to whether enrollees with chronic conditions receive adequate outpatient management services to prevent worsening of chronic conditions and more costly inpatient and emergency department services. These measures reflect access and quality.

Asthma Medication Ratio (Ages 19 - 64) (AMR)

The graph below displays the results for *Asthma Medication Ratio (AMR)*. This measure is the percentage of members 19-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Results for the measure indicated opportunities for improvement in related practices.

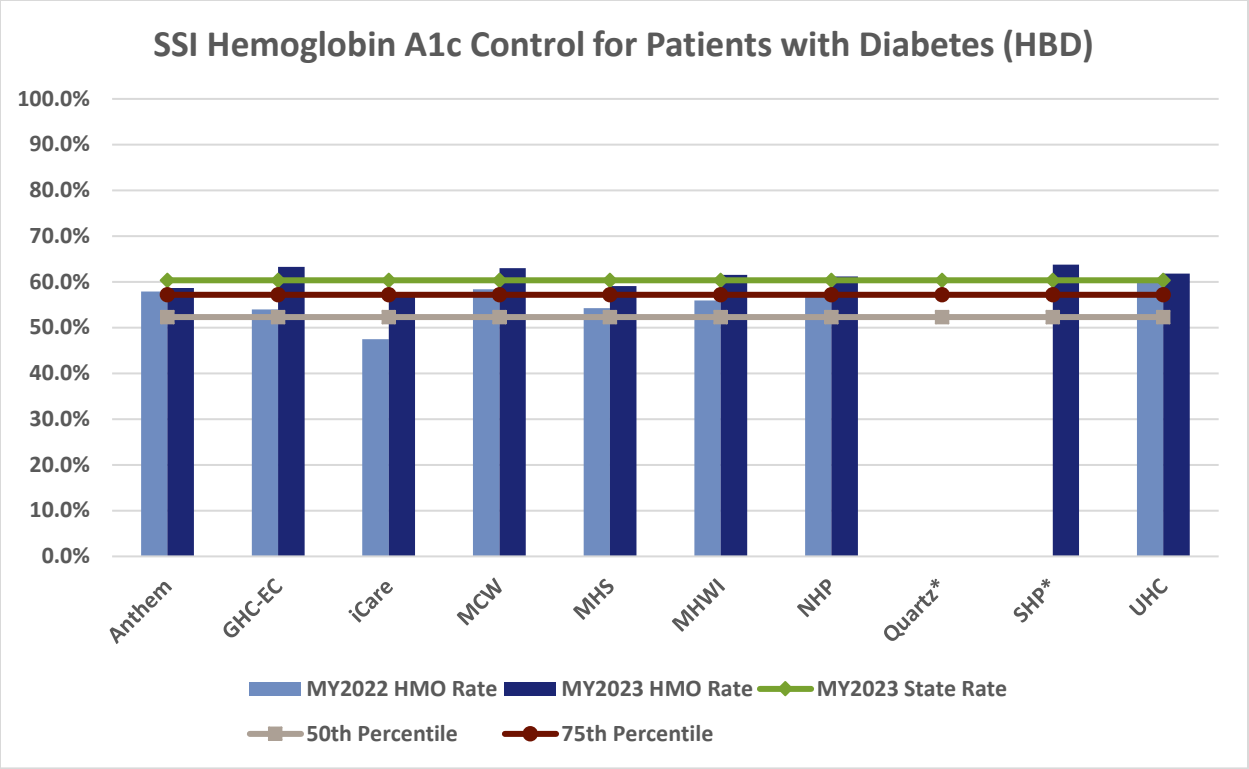


*The rate had a denominator less than 30; therefore, was not reportable.

Comprehensive Diabetes Care (Adequate HbA1c Control) (HBD)

The graph below displays the results for *Control for Patients with Diabetes (HBD)*. This measure is the percentage of members 18–75 years of age with diabetes (Type 1 and Type 2) who had HbA1c Control (<8.0%).

Results for the measure indicated strengths in related practices.



*The rate had a denominator less than 30; therefore, was not reportable.

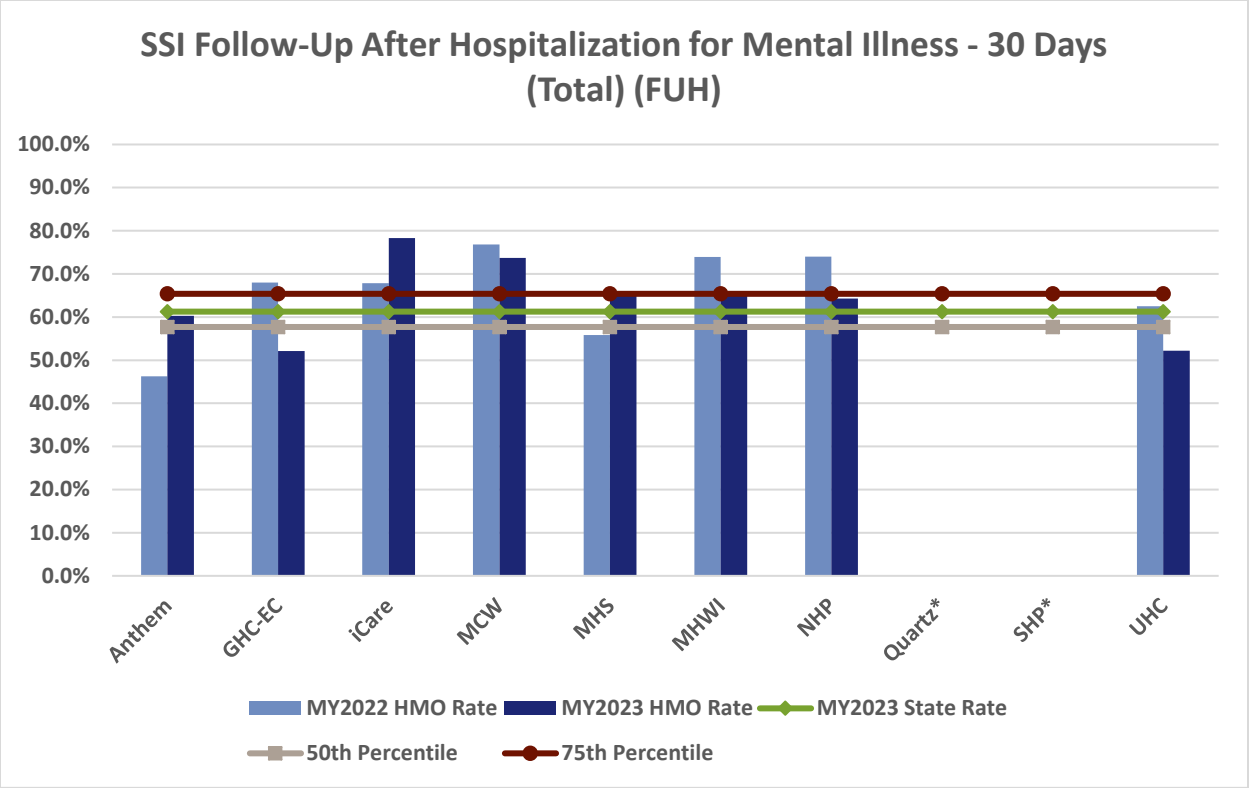
SSI Behavioral Health

Improving the management of behavioral health involves comprehensive strategies to enhance care, support, and outcomes for individuals facing mental health conditions. The measures are designed to enhance the quality of care, promote better health outcomes, and ensure that enrollees receive the necessary follow-up and preventative care. These measures reflect timeliness, access, and quality.

Follow-Up After Hospitalization for Mental Illness - 30 Days (Total) (FUH)

The graph below displays the results for *Follow-Up After Hospitalization for Mental Illness - 30 Days (Total) (FUH)*. This measure is the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge.

Results for the measure indicated compliant practices.

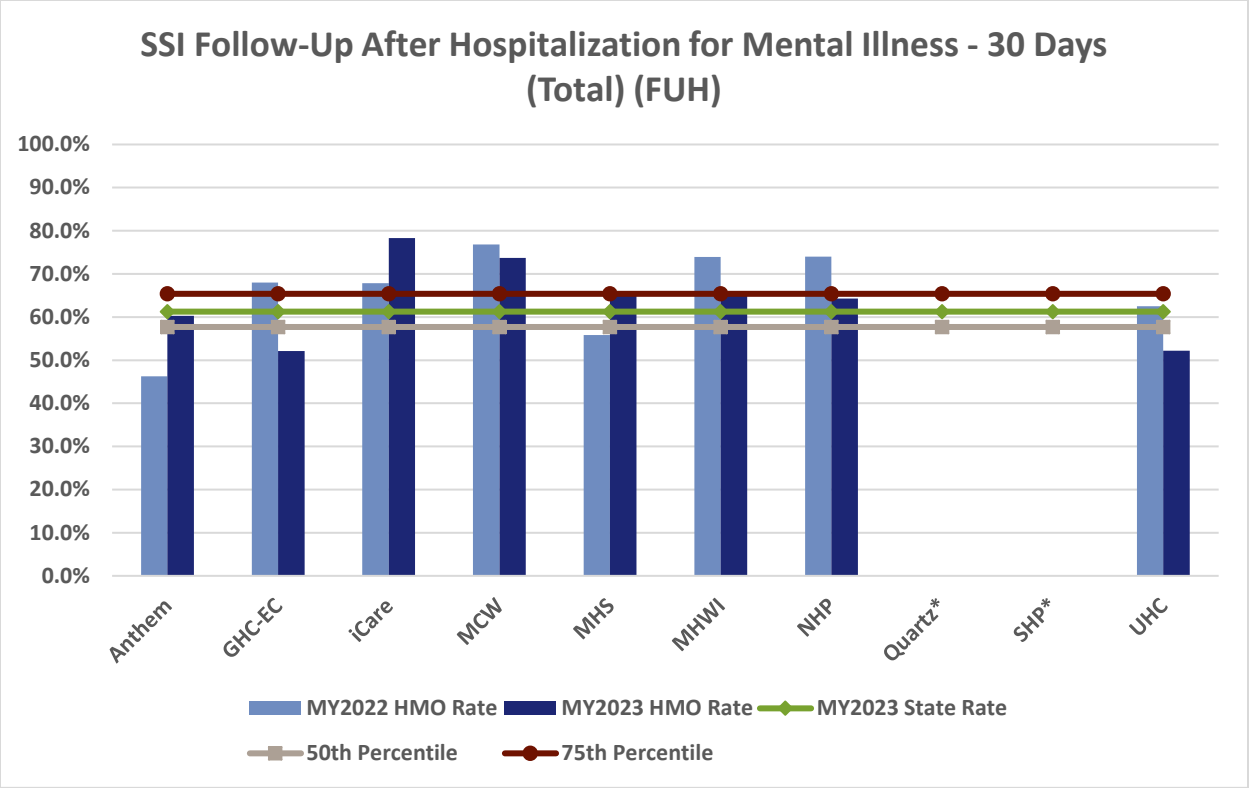


*The rate had a denominator less than 30; therefore, was not reportable.

Follow-Up After Emergency Department Visits for Mental Illness - 30 Days (Total) (FUM)

The graph below displays the results for *Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total) (FUM).* This measure is the percentage of emergency department (ED) visits for members six years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit.

Results for the measure indicated opportunities for improvement in related practices.

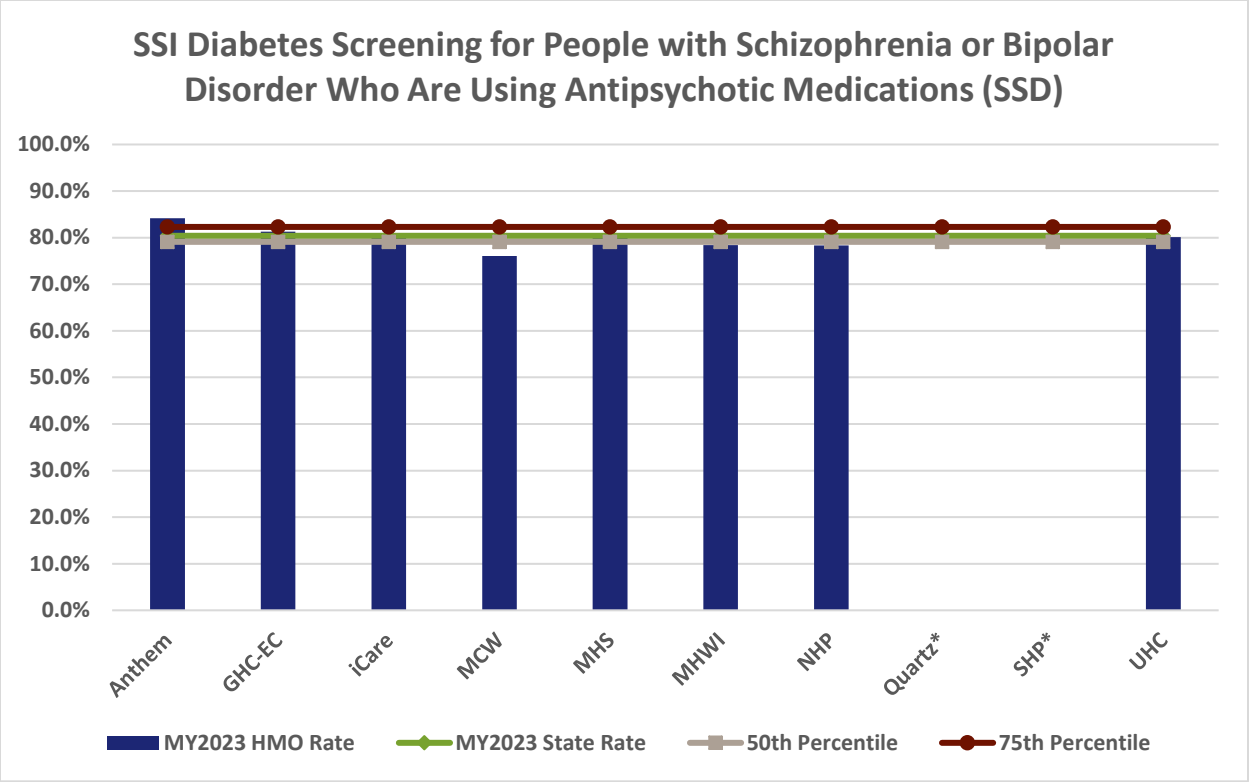


*The rate had a denominator less than 30; therefore, was not reportable.

SSI Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

The graph below displays the results for *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).* This measure is the percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. This measure was a new performance measure in CY 2023; therefore, there are no prior years for comparison.

Results for the measure indicated compliant practices.



*The rate had a denominator less than 30; therefore, was not reportable.

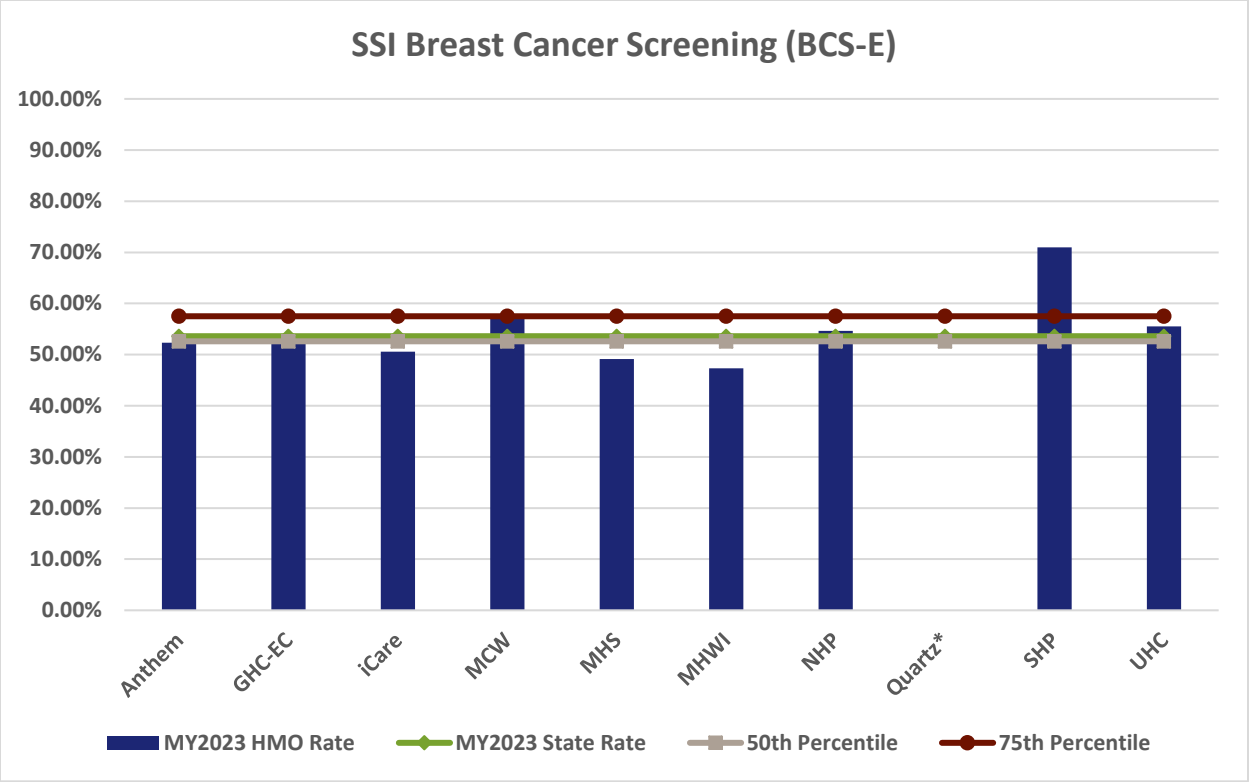
SSI Preventative Health

Promoting preventative care is a proactive apporach to healthcare, designed to improve the quality of life for medically complex SSI enrollees. Preventative health and screening measures relate to whether enrollees receive adequate preventive care needed to prevent chronic conditions or other acute health problems. These measures reflect access and quality.

SSI Breast Cancer Screening (BCS-E)

The graph below displays the results for *Breast Cancer Screening (BCS-E)*. This measure is the percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. This measure was a new performance measure in CY 2023; therefore, there are no prior years for comparison.

Results for the measure indicated compliant practices.



*The rate had a denominator less than 30; therefore, was not reportable.

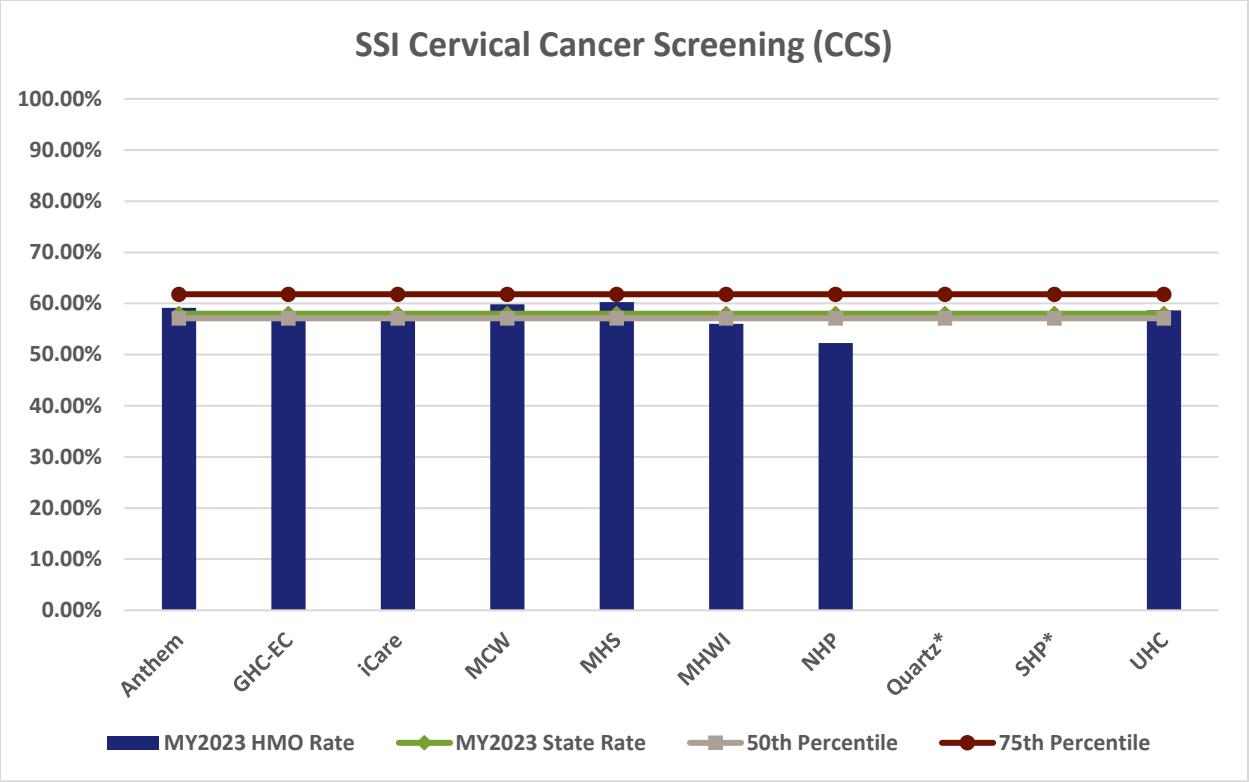
SSI Cervical Cancer Screening (CCS)

The graph below displays the results for *Cervical Cancer Screening (CCS)*. This measure is the percentage of women 21–64 years of age who were screened for cervical cancer using any of the following criteria:

- Women 21–64 years of age who had cervical cytology performed within the last three years;
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years; or
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last five years.

This measure was a new performance measure in CY 2023; therefore, there are no prior years for comparison.

Results for the measure indicated compliant practices.



*The rate had a denominator less than 30; therefore, was not reportable.

Foster Care Medical Home

DHS has identified eight HEDIS® measures for the FCMH program. The performance measures incorporate DMS quality priorities, federally required changes for the Child Core Set, updated public health guidance, and changes within the child welfare system as a result of the 2018 Family First Prevention Services Act (FFPSA). The selected HEDIS® measures focus on preventative care and mental health follow-up for children and adolescents.

According to 42 CFR §438.360, states have the option to utilize results from a private accreditation review to avoid duplication if the requirements are comparable to standards identified in the EQR protocols and 42 CFR §438.358. The performance measures identified by DHS are NCQA HEDIS® measures, which are standardized performance measures developed by NCQA and used to objectively measure, report, and compare quality across health plans, and are validated by a certified NCQA HEDIS® auditor. MetaStar did not validate the measures but performed an analysis of the reported results.

Results

MetaStar compared the State's performance on national HEDIS® measures with national benchmarks published annually by NCQA in the *Quality Compass®*[5] report with the permission of NCQA. These benchmarks represent performance of NCQA-accredited Medicaid MCO plans and Medicaid MCO plans that are either required to report HEDIS® measures by the state agency responsible for monitoring managed Medicaid performance or opt to publicly report their HEDIS® rates. The HEDIS® measures reported to NCQA vary by plan. These national benchmarks reflect the average of the plans that reported the benchmark and are not a true national average of all managed Medicaid plans. Also, note these plans represent states with and without Medicaid expansion coverage.

Scoring Legend	
National Benchmark	**Result**
Above 75th Percentile	Strength
75th - 50th Percentile	Compliant
Below 50th Percentile	Opportunity

The MY 2023 rates are compared to the 50th and 75th percentile national benchmarks MY 2023 by measure. The following tables identify statewide rates compared to the 50th and 75th percentile benchmarks by measure.

FCMH Measures	State Rate	50th Percentile	75th Percentile	Results
Childhood Immunization Status – Combo 3 (CIS)	74.1%	64.0%	68.9%	Strength
Immunizations for Adolescents – Combo 2 (IMA)	75.3%	34.3%	40.9%	Strength
Lead Screening in Children (LSC)	92.2%	62.8%	70.1%	Strength
Ambulatory Care: Emergency Department (ED) Visits (AMB)	54.16 visits per 1,000 months	571.03 visits per 1,000 months	642.99 visits per 1,000 months	Opportunity
Outpatient Mental Health Follow-Up 7 Days After Hospitalization for Mental Illness (Ages 6 - 17) (FUH)	36.5%	46.3%	54.0%	Opportunity
Outpatient Mental Health Follow-Up 30 Days After Hospitalization for Mental Illness (Ages 6 – 17) (FUH)	52.4%	71.9%	77.5%	Opportunity

[5] Quality Compass® is a registered trademark of NCQA.

FCMH Measures	State Rate	50th Percentile	75th Percentile	Results
Outpatient Mental Health Follow-Up 7 Days After ED Visit for Mental Illness (Ages 6 - 17) (FUM)	23.0%	51.4%	63.0%	Opportunity
Outpatient Mental Health Follow-Up 30 Days After ED Visit for Mental Illness (Ages 6 - 17) (FUM)	34.4%	69.6%	77.4%	Opportunity

FCMH Preventative Services and Care of Acute and Chronic Conditions

Prioritizing preventative services and care of acute and chronic conditions for children entering out-of-home care prompts overall health and developmental wellbeing. Preventative health and screening measures relate to whether enrollees receive adequate preventive care needed to prevent chronic conditions or other acute health problems. Managing acute and chronic conditions reduce adverse outcomes. These measures reflect access and quality.

Childhood Immunization Status (Combo 3) (CIS)

This measure is the percentage of children two years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday.

Results for the measure indicated strengths in related practices.

Immunizations for Adolescents (Combo 2) (IMA)

This measure is the percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) by their 13th birthday.

Results for the measure indicated strengths in related practices.

Lead Screening in Children (LSC)

This measure is the percentage of children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Results for the measure indicated strengths in related practices.

Ambulatory Care: Emergency Department Visits (AMB)

This measure summarizes utilization of ambulatory care for emergency department visits per 1,000 months.

Results for the measure indicated opportunities for improvement in related practices.

Follow-Up After Hospitalization for Mental Illness - 7 Days (Ages 6 – 17) (FUH)

This measure is the percentage of discharges for members six – 17 years of age who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within seven days after discharge.

Results for the measure indicated opportunities for improvement in related practices.

Follow-Up After Hospitalization for Mental Illness - 30 Days (Ages 6 – 17) (FUH)

This measure is the percentage of discharges for members six – 17 years of age who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge.

Results for the measure indicated opportunities for improvement in related practices.

Follow-Up After Emergency Department Visits for Mental Illness - 7 Days (Ages 6 – 17) (FUM)

This measure is the percentage of emergency department (ED) visits for members six – 17 years of age with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within seven days of the ED visit.

Results for the measure indicated opportunities for improvement in related practices.

Follow-Up After Emergency Department Visits for Mental Illness - 30 Days (Ages 6 – 17) (FUM)

This measure is the percentage of emergency department (ED) visits for members six – 17 years of age with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit.

Results for the measure indicated opportunities for improvement in related practices.

Progress on Previous EQRO Plan Level Recommendations

MetaStar assessed the degree that each MCO effectively addressed recommendations for quality improvement made by the EQRO during the previous year's EQR. The following rating scale was applied to each MCO.

Degree to Which the MCO Addressed the Recommendations	
High	The MCO addressed all recommendations.
Medium	The MCO addressed more than half of the recommendations, but not all.
Low	The MCO addressed less than half of the recommendations.

The table below identifies the recommendations made the by the EQRO in the prior review, CY 2023 for measurements from CY 2022, the actions taken by the MCO to address the recommendations, and the degree to which the MCO addressed the recommendations.

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Anthem	– Improve rates for Immunizations for Adolescents. – Improve rates for Lead Screening in Children. – Improve rates for Postpartum Care. – Improve rates for Prenatal Care. – Improve rates for Asthma Medication Ratio. – Improve rates for Follow-Up After Emergency Department Visit for Mental Illness.	– The Lead Screening in Children rate improved through actions of the MCO. – The MCO improved the Prenatal and Postpartum Care – Postpartum rate. – The Follow-up After Hospitalization for Mental Illness – 30 Days rate for SSI improved.	Medium
CCHP	– Improve rates for Childhood Immunizations. – Improve rates for Prenatal Care.	– No progress was identified.	Low
DHP	– The organization's measures exceeded the 75th percentile; therefore, no recommendations were identified.	– N/A	Low
GHC-EC	– Improve rates for Childhood Immunizations. – Improve rates for Immunizations for Adolescents. – Improve rates for Lead Screening in Children. – Improve rates for Hemoglobin A1c Control for Patients with Diabetes.	– The MCO took actions to improve the Hemoglobin A1c Control rate for Patients with Diabetes.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
GHC-SCW	– Improve rates for Lead Screening in Children. – Improve rates for Postpartum Care.	– No progress was identified.	Low
*i*Care	– Improve rates for Childhood Immunizations. – Improve rates for Immunizations for Adolescents. – Improve rates for Postpartum Care. – Improve rates for Prenatal Care. – Improve rates for Hemoglobin A1c Control for Patients with Diabetes.	– The MCO took actions to improve Childhood Immunization Status – Combo 3 rate. – The MCO took actions to improve the Hemoglobin A1c Control rate for Patients with Diabetes.	Medium
MCHP	– Improve rates for Childhood Immunizations. – Improve rates for Immunizations for Adolescents. – Improve rates for Lead Screening in Children.	– The Lead Screening in Children rate improved through actions of the MCO.	Low
MHS	– Improve rates for Childhood Immunizations. – Improve rates for Immunizations for Adolescents. – Improve rates for Lead Screening in Children. – Improve rates for Follow-Up After Emergency Department Visit for Mental Illness. – Improve rates for Hemoglobin A1c Control for Patients with Diabetes.	– No progress was identified.	Low
MHWI	– Improve rates for Childhood Immunizations.	– No progress was identified.	Low
MCW	– Improve rates for Childhood Immunizations. – Improve rates for Immunizations for Adolescents. – Improve rates for Lead Screening in Children. – Improve rates for Postpartum Care. – Improve rates for Prenatal Care. – Improve rates for Asthma Medication Ratio.	– The MCO took actions to improve Childhood Immunization Status – Combo 3 rates. – The Lead Screening in Children rate improved through actions of the MCO. – Prenatal and postpartum care rates improved through initiatives by the MCO.	Medium
NHP	– Improve rates for Childhood Immunizations. – Improve rates for Immunizations for Adolescents. – Improve rates for Postpartum Care.	– No progress was identified.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Quartz	– Improve rates for Lead Screening in Children.	– No progress was identified.	Low
SHP	– The organization's measures exceeded the 75th percentile; therefore, no recommendations were identified.	– N/A	N/A
UHC	– Improve rates for Immunizations for Adolescents. – Improve rates for Asthma Medication Ratio.	– No progress was identified.	Low

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 organizations related to quality, timeliness, and access to services, including health care and members with special health care needs.

The Wisconsin Department of Health Services (DHS) submitted its *Accreditation Deeming Plan* to the Centers for Medicare and Medicaid Services (CMS) as an appendix to the *2021 Medicaid Managed Care Quality Strategy*. The plan deems Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PHIPs) with accreditation status from National Committee for Quality Assurance (NCQA) as compliant with most federal requirements and conducting a compliance with standards review would be duplicative. MetaStar conducted a desk review of the elements not addressed by NCQA accreditation to ensure full compliance with the managed care regulations. The Accreditation Desk Review (ADR) affirms the organization's accreditation status and evaluates compliance with the areas of the CFR not addressed by NCQA accreditation.

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

DHS directed MetaStar to continue the mandatory EQR compliance with standards review for non-accredited MCOs and PIHPs, and MCOs and PIHPs accredited by a non-recognized accreditation body, according to the usual three-year cycle. In calendar year (CY) 2023, all required health plans obtained NCQA Medicaid Accreditation. Please refer to Appendix 2 for additional information regarding the three-year review cycle and review methodology.

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

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

The review is divided into three groups of standards:

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

- Enrollee rights and protections 42 CFR §438.100
- Availability of services 42 CFR §438.206
- Assurances of adequate capacity and services 42 CFR §438.207
- Coordination and continuity of care 42 CFR §438.208
- Coverage and authorization of services 42 CFR §438.210
- Provider selection 42 CFR §438.214
- Confidentiality 42 CFR §438.224
- Subcontractual relationships and delegation 42 CFR §438.230
- Practice guidelines 42 CFR §438.236
- Health information systems 42 CFR §438.242

Quality Assessment and Performance Improvement (QAPI):

- Quality assessment and performance improvement program 42 CFR §438.330

Grievance Systems:

- Grievance and appeal systems 42 CFR §438.228

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

This calendar year is the second year of the cycle; therefore, QAPI and Grievance Systems standards were reviewed. The combined compliance score of all standards is presented in the *Overall Results* section of this report and includes all standards reviewed in the two-year cycle, Review Cycle Calendar Year 2023 (CY 2023)/Calendar Year 2024 (CY 2024).

The following organizations and programs were evaluated:

Organizations	Program(s)
Anthem Blue Cross and Blue Shield Health Plan (Anthem)	BC+ SSI
Chorus Community Health Plan, Inc. (CCHP)	BC+ FCMH
Dean Health Plan, Inc. (DHP)	BC+

Organizations	Program(s)
Group Health Cooperative of South-Central Wisconsin (GHC-SCW)	BC+
Independent Care Health Plan (*i*Care)	BC+ SSI
MercyCare Health Plans (MCHP)	BC+
MHS Health Wisconsin (MHS)	BC+ SSI
Molina HealthCare of Wisconsin (MHWI)	BC+ SSI
Network Health Plan (NHP)	BC+ SSI
Quartz Health Solutions, Inc. (Quartz)	BC+ SSI
Security Health Plan of Wisconsin, Inc. (SHP)	BC+ SSI
United Healthcare Community Plan (UHC)	BC+ SSI

Overall Compliance Results by MCO

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

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

MetaStar did not conduct a Compliance with Standards review during CY 2024 for any MCOs or PIHPs that were not NCQA Medicaid accredited prior to December 31, 2023. Group Health Cooperative of Eau Claire received a full Compliance with Standards review in CY 2022 and did not participant in the accreditation desk review in CY 2024. Independent Care Health Plan received a full Compliance with Standards review in CY 2021, did not participate in the accreditation desk review in CY 2023, and participated in the accreditation desk review in CY 2024. Wraparound Milwaukee received a full Compliance with Standards review in CY 2021 and ceased program operations in CY 2024. My Choice Wisconsin, Inc. was acquired by Molina HealthCare of Wisconsin in CY 2023. MetaStar conducted 12 accreditation desk reviews for

MCOs holding NCQA Medicaid Accreditation. The following table indicates the MCOs' overall level of compliance in the CY 2024 Compliance with Standards review.

For all MCOs, the statewide overall compliance score is 89.4 percent, and a rating of Very Good. The score is based on the review of the MCO Standards in CY 2023 and the QAPI and Grievances Systems standards in CY 2024, which make up Review Cycle CY 2023/CY 2024. The table below indicates the State's overall level of compliance with all standards.

Accreditation Desk Review Cycle CY 2023/CY 2024			
Focus Area	**Scoring Elements**	**Percentage**	**Rating**
MCO Standards: Provider Network, Care Management, and Enrollee Rights	870/985	88.3%	Very Good
QAPI	219/240	91.3%	Excellent
Grievance Systems	575/648	88.7%	Very Good
Overall	**1,664/1,873**	**88.8%**	**Very Good**

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. Additionally, Appendix 5 includes results for each standard by MCO.

Observation and Analysis: QAPI Standards

The 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 ADR. The table on the next page indicates the MCO's compliance with these standards.

Quality Assessment and Performance Improvement Standards CY 2024			
Standard	**Scoring Elements**	**Percentage**	**Rating**
Q1	103/108	95.4%	Excellent
Q2	82/84	97.6%	Excellent
Q3*	N/A	N/A	N/A
Q4*	N/A	N/A	N/A
Q5	34/48	70.8%	Good
Overall	**219/240**	**91.3%**	**Excellent**

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

Q1 Quality assessment program - 42 CFR §438.330(a)

MCOs must establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members. The QAPI program must meet minimum requirements related to its administrative structures, stakeholder participation, quality workplan, and monitoring activities. The standard, Q1, evaluated each MCO on nine possible scoring elements. Collectively, the MCOs satisfied requirements for 103 out of 108 scoring elements, for a score of 95.4 percent, and a rating of Excellent.

The MCOs' NCQA accreditation results and internal documents and processes demonstrated the MCOs have systems in place to ensure the quality management program has clear and appropriate structures and includes staff, and provider participation.

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

MCOs shall maintain documentation and monitoring of the required activities of the Quality Management program. The program must monitor and evaluate the quality of clinical care on an ongoing basis, identify patterns of over and underutilization of services, monitor and evaluate clinical and non-clinical areas including member satisfaction, and determine medical necessity and appropriateness for initial and continuing authorization of services. The standard, Q2, evaluated each MCO on seven possible scoring elements. Collectively, the MCOs satisfied requirements for 82 out of 84 scoring elements, for a score of 97.6 percent, and a rating of Excellent.

The MCOs' NCQA accreditation results and internal documents and processes demonstrated the MCOs' quality management program incorporates standardized quality indicators that

monitor and evaluate over and underutilization of services, and have systems in place for determining medical necessity of initial and continuing authorization of services.

Q3 Performance measurement - 42 CFR §438.330(c)

These requirements are evaluated through the Performance Measure Validation (PMV) activity, which is conducted and reported on a different cycle than the ADR.

Q4 Performance improvement projects - §42 CFR 438.330(d)

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

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

MCOs must develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program, and determine whether the program has achieved improvement in the quality of service provided to members. The standard, Q5, evaluated each MCO on four possible scoring elements. Collectively, the MCOs satisfied requirements for 34 out of 48 scoring elements, for a score of 70.8 percent, and a rating of Good.

The MCOs' NCQA accreditation results demonstrated the MCOs have processes in place to evaluate the effectiveness of its QAPI program and establish new goals and objectives based on findings from improvement activities, performance measures, and member satisfaction surveys. Scoring element Q5.3 required the MCOs' QAPI workplan to include its annual plan to meet its pay-for-performance (P4P) goals and submit NCQA audited P4P results to DHS on time. The quality workplans for CCHP, *i*Care, MHWI, Quartz, GHC-SCW, MCHW, and DHP did not outline the plan to submit P4P results to DHS.

Scoring element Q5.4 required the MCOs' QAPI workplan to include annual Performance Improvement Project (PIP) topic selection, implementation, monitoring, and final report submission of the PIP reports to DHS and to the EQRO. The QAPI workplans from Anthem, CCHP, *i*Care, MHWI, Quartz, GHC-SCW, and MCHP did not include the submission of the PIP reports to DHS and/or the EQRO.

Observation and Analysis: Grievance Systems

The 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 MCOs' compliance with these standards.

Grievance Systems Standards			
Standard	**Scoring Elements**	**Percentage**	**Rating**
G1	58/60	96.7%	Excellent
G2	83/84	98.8%	Excellent
G3	106/120	88.3%	Very Good
G4	71/72	98.6%	Excellent
G5	134/156	85.9%	Very Good
G6	30/36	83.3%	Very Good
G7	8/24	33.3%	Poor
G8	23/24	95.8%	Excellent
G9	39/48	81.3%	Very Good
G10	23/24	95.8%	Excellent
Overall	**575/648**	**88.7%**	**Very Good**

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, evaluated each MCO on five possible scoring elements. Collectively, the MCOs satisfied requirements for 58 out of 60 scoring elements, for a score of 96.7 percent, and a rating of Excellent.

The MCOs' NCQA accreditation results and internal documents and processes demonstrated the MCOs have a grievance and appeal system in place for members. Documentation demonstrated members are informed about the existence of the grievance and appeal processes and how to use them.

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, evaluated each MCO on seven possible scoring elements. Collectively, the MCOs satisfied requirements for 83 out of 84 scoring elements, for a score of 98.8 percent, and a rating of Excellent.

The MCOs' NCQA accreditation results and internal documents and processes demonstrated the MCOs ensure members are able to file a grievance at any time and follow the required

timeframes when members request an appeal. A member or the member's legal decision makers may file a grievance or appeal orally or in writing.

G3 Notice to members - 42 CFR §438.404

MCOs must comply with content requirements and timing of *Notices of Adverse Benefit Determination*. Notices to members must be in writing and meet language and format requirements to ensure ease of understanding for members. The standard, G3, evaluated each MCO on 10 possible scoring elements. Collectively, the MCOs satisfied requirements for 106 out of 120 scoring elements, for a score of 88.3 percent, and a rating of Very Good.

The MCOs' NCQA accreditation results and internal documents and processes demonstrated the MCOs have processes in place to ensure *Notices of Adverse Benefit Determination* include all required criteria.

Scoring element G3.2 required the MCOs to mail a notice of termination, suspension, or reduction of previously authorized Medicaid-covered services at least 10 days before the date of action. The documents submitted by CCHP, DHP, MCHP, and Quartz did not detail the timeframe for advance notice.

Scoring element G3.3 indicated the MCOs may send a notice of termination, suspension, or reduction of a previously authorized Medicaid-covered service no later than the date of action in any of the following occurrence:

- Death of a member;
- Notice from a member they no longer wish for services;
- Member has been admitted to an ineligible institution;
- Member's whereabouts are unknown;
- Member has been accepted for Medicaid services in another area;
- A change in the member's level of medical care prescribed by the physician;
- Adverse determination made with regard to a preadmission screening requirement; or
- Member is being transferred or discharged in less than 10 days as a result of health and safety concerns, improved health, urgent medical needs or has not resided in the nursing facility for 30 days.

The documents submitted by Anthem, CCHP, DHP, MCHP, and Quartz did not include any or all of the required occurrences.

Scoring element G3.4 identified the MCOs may shorten the period of advance notice to five days before the effective date of action if the MCO has facts of probable fraud by the member, and the facts have been verified through secondary sources. The documents submitted by CCHP, DHP, *i*Care, MCHP, and Quartz did not include this requirement.

G4 Handling of grievances and appeals - 42 CFR §438.406

MCOs must comply with requirements for handling of grievances and appeals, including acknowledgement, grievance and appeal committee composition and requirements, and special requirements for appeals. The standard, G4, evaluated each MCO on six possible scoring elements. Collectively, the MCOs satisfied requirements for 71 out of 72 scoring elements, for a score of 98.6 percent, and a rating of Excellent.

The MCOs' NCQA accreditation results and internal documents and processes demonstrated the MCOs have processes in place to give members any reasonable assistance in completing forms and taking other procedural steps in the grievance and appeal process. The MCOs' processes ensure individuals who make decisions on grievances and appeals, the grievance and appeal committee, have not been involved in any previous level of review or decision-making related to the issue. The committees also include appropriate health care professionals. The MCOs' special requirements for appeals include written confirmation of grievances and appeals; the opportunity for members to present evidence and allegation of fact or law, in person or in writing; and provide members the opportunity to examine their records.

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, evaluated each MCO on 13 possible scoring elements. Collectively, the MCOs satisfied requirements for 133 out of 156 scoring elements, for a score of 85.3 percent, and a rating of Very Good.

The MCOs' NCQA accreditation results demonstrated the MCOs have systems in place to ensure grievances and appeals are resolved as expeditiously as the member's situation and health condition requires and within the standard and expedited timeframes as required.

Scoring element G5.4 required the MCOs to do the following if a grievance or appeal is submitted by an individual purporting to be the member's authorized representative and the MCO does not have the documented consent of the member for the individual to act as the member's representative on file:

- Attempt to follow up with the member to confirm their desire for the grievance or appeal to proceed;
- Inform the member of the need to provide written consent for an individual to act as the member's authorized representative in the grievance or appeal, and in the absence of the consent the grievance or appeal will be processed as a request from the member;
- If the member does not wish to proceed with the grievance or appeal, the MCOs must dismiss the grievance or appeal and send written notice to the member; and
- If no contact is made with the member within the designated timeframe, the MCOs must dismiss the grievance or appeal and send written notice to the member.

Documents submitted by CCHP, DHP, MHS, NHP, Quartz, and UHC did not evidence all of the requirements for grievances and appeals submitted by individuals purporting to be an authorized representative.

Scoring element G5.8 ensured the written notice of grievance resolution is written in a format and language that meets the requirements set forth in the DHS-MCO contract and the *HMO and PIHP Communication, Outreach, and Marketing Guide.* Documents submitted by CCHP, GHC-SCW, MCHP, MHWI, and UHC did not include or reference the language or formatting requirements for grievance resolution letters.

Scoring element G5.10 required the MCOs to issue separate written notice of appeal resolution for each adverse benefit determination appealed by a member. Documents submitted by CCHP, DHP, and UHC did not include information that each adverse benefit determination that is appealed must receive a separate notice of appeal resolution.

Scoring element G5.12 indicated members may request a State Fair Hearing no later than 90 calendar days after receiving the MCOs' notice upholding the adverse benefit determination. The date of receipt is presumed within five calendar days of the date the notice was mailed. Documents submitted by CCHP, GHC-SCW, and Quartz did not account for the timeframe the member has to receive the notice.

Scoring element G5.13 required the MCOs to provide all State Fair Hearing relevant materials, including the MCOs' denial letters, all pertinent medical or dental records, and any other pertinent documentation as determined by DHS, to the appropriate party within five business days or sooner if possible. Documents submitted by CCHP, DHP, and Quartz did not specify the specific documents the MCO must provide to the requesting party in the required timeframe.

G6 Expedited resolution of appeals - 42 CFR §438.410

MCOs must comply with requirements for an expedited review process for appeals. The standard, G6, evaluated each MCO on three possible scoring elements. Collectively, the MCOs satisfied requirements for 30 out of 36 scoring elements, for a score of 83.3 percent, and a rating of Very Good.

The MCOs' NCQA accreditation results demonstrated the MCOs have processes in place to establish and maintain an expedited review process for appeals, when the MCOs determine or the providers indicate that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. If a request for an expedited resolution is denied, the MCOs have systems in place to transfer the appeal to the standard resolution timeframe and make reasonable efforts to give the member prompt oral notice of the denial.

Scoring element G6.2 ensured that punitive action is not taken against anyone who requests an expedited resolution or supports a member's appeal. Documents submitted by Anthem, CCHP, DHP, *i*Care, MHWI, and UHC did not include the requirement that contracted providers cannot take punitive action against anyone requesting an expedited resolution or supporting a member's 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, evaluated each MCO on two possible scoring elements. Collectively, the MCOs satisfied requirements for eight out of 24 scoring elements, for a score of 33.3 percent, and a rating of Poor.

Scoring element G7.1 ensured the MCOs distribute member grievance and appeal rights and corresponding documents to providers and subcontractors. Documents submitted by CCHP, DHP, GHC-SCW, MHS, MHWI, Quartz, and UHC did not demonstrate compliance with this requirement.

Scoring element G7.2 required the MCOs to ensure providers and subcontractors have written procedures for describing how members are informed of denied services and make copies of the written procedures available for review upon request by DHS. Documents submitted by CCHP, DHP, GHC-SCW, MHS, MHWI, Quartz, and UHC did not include this requirement.

G8 Record keeping requirements - 42 CFR §438.416

MCOs must comply with recordkeeping requirements for grievances and appeals. The standard, G8, evaluated each MCO on two possible scoring elements. Collectively, the MCOs satisfied requirements for 23 out of 24 scoring elements, for a score of 95.8 percent, and a rating of Excellent.

The MCOs' NCQA accreditation results and internal documents and processes demonstrated the MCO has recordkeeping systems in place to ensure grievance and appeals are monitored and accounted for.

G9 Continuation of benefits - 42 CFR §438.420

MCOs must comply with requirements for continuation of benefits, duration, and member responsibility for costs. The standard, G9, evaluated each MCO on four possible scoring elements. Collectively, the MCOs satisfied requirements for 39 out of 48 scoring elements, for a score of 81.3 percent, and a rating of Very Good.

The MCOs ensured that written notices are provided to members that inform them of the right to continue services while an appeal is pending, and that they could be held responsible to reimburse the MCOs for the cost of these services if the appeal decision is not in the member's favor.

Scoring element G9.2 required the MCOs to continue member benefits when a member files a request for an appeal under specific contract requirements. Documents submitted by Anthem and UHC did not include one of the five requirements, which required services to continue if the period covered by the original authorization has not expired. Documents submitted by DHP, GHC-SCW, and Quartz only included one of the five requirements, which required services to continue if the appeal involved the termination, suspension, or reduction of previously authorized services.

Scoring element G9.3 required the MCOs to continue or reinstate the member's benefits at the member's request while the appeal or State Fair Hearing is pending, until one of the following occurs:

- The member withdraws the appeal or request for a State Fair Hearing;
- The member fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the MCO sends the notice of resolution to the member's appeal; or,
- The Division of Hearings and Appeals issues a hearing decision adverse to the member.

Documents submitted by DHP and Quartz did not demonstrate compliance with this requirement.

G10 Effectuation of reversed appeal resolution - 42 CFR §438.424

MCOs must comply with requirements to reinstate benefits for reversed denials. The standard, G10, evaluated each MCO on two possible scoring elements. Collectively, the MCOs satisfied requirements for 23 out of 24 scoring elements, for a score of 95.8 percent, and a rating of Excellent.

The MCOs ensured if the MCO or State Fair Hearing officer reverses a decision about services not furnished during the appeal, the MCOs 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 MCOs pay for those services.

Progress on Previous EQRO Plan Level Recommendations

MetaStar assessed the degree that each MCO effectively addressed recommendations for quality improvement made by the EQRO during the previous year's EQR. The following rating scale was applied to each MCO.

Degree to Which the MCO Addressed the Recommendations	
High	The MCO addressed all recommendations.
Medium	The MCO addressed more than half of the recommendations, but not all.
Low	The MCO addressed less than half of the recommendations.

The following table identifies the recommendations made the by the EQRO in the prior review, CY 2021, the actions taken by the MCO to address the recommendations, and the degree to which the MCO addressed the recommendations.

MCO	Previous Review's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Anthem	– Update the *Member Appeals – WI* policy to specify only one level of appeal at the MCO. – Update the provider onboarding and orientation process to ensure all providers receive the *Member*	– The organization revised documents to specify one level of appeal for members. – The organization implemented a process to ensure all providers receive the *Member Grievance and*	High

MCO	Previous Review's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	Grievance and Appeals Guide and *Ombudsman Brochure* as required. – Update the *Member Grievances* policy to ensure all required recordkeeping elements are retained for grievances and appeals	*Appeals Guide* and *Ombudsman Brochure* as required. – The organization amended documentation to ensure all required recordkeeping elements are retained for grievances and appeals.	
CCHP	– Develop and implement a policy and procedure to address the issuance of notices of adverse benefit determination when previously authorized services are reduced, terminated, or suspended. – Amend the *Timeliness of Utilization Management Decisions* policy and procedure to include the issuance of written notification of adverse benefit determinations to members as well as providers in the following circumstances: ○ When services are denied, terminated, reduced, or suspended; ○ When claims are denied; and ○ When the MCO is unable to decide on a service authorization request in a timely manner. – Revise the *Member Complaints Policy and Procedure* to address the provision of an initial response to the member within 10 business days of receipt of a grievance, and to provide assurances that the format of the grievance resolution notification letter that meets the standards described in the DHS *HMO and PIHP Communication, Outreach, and Marketing Guide.* – Update MCO documentation to specify that parties to an appeal may include a representative of a deceased enrollee's estate. – Amend the *Utilization Management Member Appeal Policy and*	– The organization revised documents to include the issuance of written notification of adverse benefit determinations to members as well as providers in the following circumstances: ○ When services are denied, terminated, reduced, or suspended; ○ When claims are denied; and ○ When the organization is unable to decide on a service authorization request in a timely manner. – The organization amended grievance and appeal documents to specify that parties to an appeal may include a representative of a deceased enrollee's estate. – The organization amended utilization management documents to include the requirement to authorize or provide disputed services as expeditiously as the member's health condition requires, but no later than 72 hours from the date the MCO receives notification that its appeals process or State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending.	Low

MCO	Previous Review's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	Procedure to include the following requirements: ○ The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner if possible; and, ○ The requirement to authorize or provide disputed services as expeditiously as the member's health condition requires, but no later than 72 hours from the date the MCO receives notification that its appeals process or State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending.		
DHP	– Update the *Timeframe Standards for Medical UM Determinations – BC+* policy to include: ○ Notices for termination, suspension or reduction of previously authorized services or denial of payment are issued with the timeframes required by DHS. ○ Providing members written notice when a decision-making timeframe must be extended. – Revise the *Medicaid Grievance and Appeals – WI* policy to include: ○ The circumstances under which the MCO may extend the timeframe to resolve a grievance or appeal; ○ The circumstances for ending the continuation of benefits while the appeal or State Fair Hearing is pending; and, ○ The details for effectuation of reversed appeal resolutions. – Update the provider notification process and related documents to ensure each provider receives the most recent copy of the	– The organization updated documents to include the following: ○ Issuance of written notification of adverse benefit determinations to members and providers when claims are denied; ○ The provision of written notice to members when a decision-making timeframe is extended; and ○ The circumstances under which the organization may extend the timeframe to resolve a grievance or appeal.	Low

MCO	Previous Review's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	Ombudsman Brochure and *Member Grievance and Appeals Guide* as required.		
GHC-SCW	– Incorporate the requirement to have a mechanism to detect both under and overutilization of services into the quality improvement program. – Develop a policy and procedure to address the issuance of notices of adverse benefit determination when previously authorized services are reduced, terminated, or suspended. – Amend the *Pre-Service, Concurrent & Post Services Reviews and Timely Determinations* policy and procedure to include the following: ○ The issuance of written notifications of adverse benefit determination when claims are denied and when the MCO is unable to decide on a service authorization request in a timely manner; and, ○ The ability of members and providers to request an extension to the standard authorization decision-making timeframe. – Ensure the MCO informs members of the right to file a grievance if he or she disagrees with a decision to extend the standard service authorization timeframe. – Revise the *Appeal/Grievance Process – Member Appeals Committee* policy and procedure to identify or incorporate the following: ○ If the MCO fails to adhere to the notice and timing requirements for resolving appeals, then the member is determined to have exhausted the GHC-SCW's appeal process and the member may initiate a State Fair Hearing;	– The organization evaluated the overall effectiveness of the quality program annually to determine whether the program demonstrated improvement. – The organization implemented a process to issue notices of adverse benefit determination when previously authorized services are reduced, terminated, or suspended, and when new service requests are denied. – The organization amended documents to address the ability of members and providers to request an extension to the standard authorization decision-making timeframe, and the right to file a grievance if they disagree with the decision to extend the timeframe. – The organization revised documents to identify and incorporate the following: ○ A member's ability to initiate a State Fair Hearing if the organization fails to adhere to the notice and timing requirements for resolving appeals; ○ The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner, if possible; and ○ That punitive action will not be taken against anyone who requests an expedited resolution of an appeal or supports a member's appeal.	Medium

MCO	Previous Review's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	○ Provide assurances that the format of the grievance resolution notification letter meets the standards described in the DHS *HMO and PIHP Communication, Outreach, and Marketing Guide*; ○ The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner if possible; ○ Specify that punitive action will not be taken against anyone who requests an expedited resolution of an appeal or supports a member's appeal; and, ○ The processes related to continuation of benefits and recovery of the cost of services continued during the appeals process. – Clearly state in the *Appeal/Grievance Process – Member Appeals Committee* policy and procedure that the MCO does not deny requests for expedited appeals, and processes all requests for expedited appeals according to the expedited appeal timeframe.		
*i*Care	– Update the Care Management Quality Improvement Committee membership to include those specializing in mental health, substance abuse, or dental care on a consultant basis as required. – Update guidance to include all required timeframes for issuing written notices of adverse benefit determinations to members. – Revise guidance and other related materials to include the member's right to file a grievance if he or she disagrees with an extension to the timeframe for a standard service authorization decision.	– The organization updated the membership of the Quality Improvement Committee to include membership from a variety of disciplines. – The organization updated documentation to ensure providers or authorized representatives may request an appeal, file a grievance, or request a State Fair Hearing on behalf of the member. – The organization amended documents to include the ability of members and providers to request	Medium

MCO	Previous Review's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Provide the *HMO and PIHP Grievances and Appeals Guide* to providers as required. – Update written guidance for the MCO's appeal process to include that the MCO must pay for services provided during an appeal if the MCO appeal process or State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services during the appeal. – Revise the *Medicaid Appeal Process* policy to include the following requirements: ○ Attempts to resolve issues or concerns without formal hearings whenever possible; ○ Clear guidance to staff for standard appeal extension requirements; ○ Identification that members must request a State Fair Hearing no later than 90 calendar days from the date of the MCO's notice of resolution; and, ○ Provision of relevant materials to appropriate parties for a State Fair Hearing within five business days of the request for information. – Update the *Medicaid Grievance Process* policy to include the ability of a provider to file a grievance on behalf of a member.	an extension to the standard authorization decision-making timeframe, and the right to file a grievance if they disagree with the decision to extend the timeframe. – The organization ensured the *HMO and PIHP Grievances and Appeals Guide* is provided to gatekeepers, providers, subcontractors, and Independent Practice Associations as required. – The organization updated documentation to include the requirement that if the health plan or the Division of Hearings and Appeals reverses a decision to deny authorization of services, and the member received the disputed services while the appeal is pending, the health plan must pay for those services. – The organization revised internal documentation to include: ○ The requirement for the MCO to attempt to resolve issues and concerns without formal hearings or reviews whenever possible; ○ The timeframe for members to request a State Fair Hearing after receiving the organization's notice of resolution; and ○ The provision of relevant materials regarding a State Fair Hearing upon request, to the appropriate parties within five business days.	
MCHP	– Update the provider notification process and related documents to ensure each provider receives the most recent copy of the *Ombudsman Brochure* as required.	– The organization distributed the informational flyer on member grievance and appeals rights to its gatekeepers, providers, subcontractors, and Independent	High

MCO	Previous Review's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
		Practice Associations at the time of contracting.	
MHS	– Amend the *Timeliness of UM Decisions and Notifications* policy and procedure to include the ability of a member or provider to request an extension to the standard and expedited decision-making timeframes. – Incorporate a mechanism to detect under and overutilization of services into the quality program and quality work plan. – Amend the *Appeal of UM Decisions* policy and procedure to include the following information: ○ Grievance and appeal system requirements specific to the state of Wisconsin, including the requirement that the MCO may only have one level of appeal for members; ○ The ability of members to request an extension to the appeal resolution timeframe; ○ The provision of oral notification to the member of the extension to the appeal resolution timeframe; ○ The timeframe for issuance of written notification to the member when the appeal resolution timeframe is extended; ○ The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner if possible; and ○ The timeframe by which the MCO provides information about the grievance and appeal system to all providers and subcontractors, including the *Ombudsman Brochure*.	– The organization included an evaluation of under and overutilization of services in quality management program. – The organization implemented a process to ensure written notifications of adverse benefit determinations are issued as required. – The organization ensured practices are compliant with requirements for an expedited review process for appeals. – The organization updated internal documentation to include: ○ Grievance and appeal system requirements specific to the state of Wisconsin, including the requirement that the organization may only have one level of appeal for members; ○ The ability of members to request an extension to the appeal resolution timeframe; ○ The provision of oral notification to the member of the extension to the appeal resolution timeframe; ○ The timeframe for issuance of written notification to the member when the appeal resolution timeframe is extended; and ○ The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner if possible.	Medium

MCO	Previous Review's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Develop and implement a process related to the issuance of written notification of adverse benefit determinations when claims are denied. – Revise the *Timeliness of UM Decisions and Notifications* policy and procedure to address the following DHS-MCO contract requirements: ○ Notifying members of the right to file a grievance if they disagree with an extension to the standard service authorization decision timeframe; ○ The timeframe for issuing a written notice of denial to a member if a request is denied; and ○ The length of time allowed for an extension to the expedited service authorization decision timeframe if the member requests the extension. – Include an evaluation of under and overutilization of services in the annual *Medicaid QI Program Evaluation.*		
MHWI	– Update the provider notification process and related documents to ensure each provider receives the most recent copy of the *Ombudsman Brochure* and *Member Grievance and Appeals Guide* as required.	– The organization did not address the prior review's recommendations.	Low
NHP	– Amend the *Timeliness of UM Decisions and Notifications* policy and procedure to include the ability of a member or provider to request an extension to the standard and expedited decision-making timeframes. – Incorporate a mechanism to detect under and overutilization of services into the quality program and quality work plan.	– The organization included an evaluation of under and overutilization of services in quality management program. – The organization ensured requirements for an expedited review process for appeals. – The organization updated internal documentation to include:	Medium

MCO	Previous Review's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Amend the *Appeal of UM Decisions* policy and procedure to include the following information: ○ Grievance and appeal system requirements specific to the State of Wisconsin, including the requirement that the MCO may only have one level of appeal for members; ○ The ability of members to request an extension to the appeal resolution timeframe; ○ The provision of oral notification to the member of the extension to the appeal resolution timeframe; ○ The timeframe for issuance of written notification to the member when the appeal resolution timeframe is extended; ○ The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner if possible; and ○ The timeframe by which the MCO provides information about the grievance and appeal system to all providers and subcontractors, including the *Ombudsman Brochure*. – Develop and implement a process related to the issuance of written notification of adverse benefit determinations when claims are denied. – Revise the *Timeliness of UM Decisions and Notifications* policy and procedure to address the following DHS-MCO contract requirements: ○ Notifying members of the right to file a grievance if they disagree with an extension to the standard service authorization decision timeframe;	○ Grievance and appeal system requirements specific to the State of Wisconsin, including the requirement that the MCO may only have one level of appeal for members; ○ The ability of members to request an extension to the appeal resolution timeframe; ○ The provision of oral notification to the member of the extension to the appeal resolution timeframe; ○ The timeframe for issuance of written notification to the member when the appeal resolution timeframe is extended; and – The provision of all relevant material regarding a State Fair Hearing upon request, to the appropriate party within five business days or sooner if possible. The organization developed a process related to the issuance of written notification of adverse benefit determinations when claims are denied.	

MCO	Previous Review's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	○ The timeframe for issuing a written notice of denial to a member if a request is denied; and ○ The length of time allowed for an extension to the expedited service authorization decision timeframe if the member requests the extension. – Include an evaluation of under and overutilization of services in the annual *Medicaid QI Program Evaluation.* – Clearly state in the *Appeal of UM Decisions* policy and procedure that the MCO does not deny requests for expedited appeals, and processes all requests for expedited appeals according to the expedited appeal timeframe.		
Quartz	– Update the provider notification process and related documents to ensure each provider receives the most recent copy of the *Ombudsman Brochure* and *Member Grievance and Appeals Guide* as required. – Revise the *BadgerCare Plus Appeal and Grievance* policy to include: ○ The circumstances for ending the continuation of benefits while the appeal or State Fair Hearing is pending.	– The organization did not address the prior review's recommendations.	Low
SHP	– Incorporate the requirement to have a mechanism to detect both under and overutilization of services into the quality improvement program. – Develop a policy and procedure to address the issuance of notices of adverse benefit determination when previously authorized services are reduced, terminated, or suspended. – Revise the *BadgerCare and SSI Appeals* policy and procedure to	– The organization ensured processes included a mechanism to detect both under and overutilization of services in the quality improvement program. – The organization's practices demonstrated compliance with issuing notices of adverse benefit determination when previously authorized services are reduced, terminated, or suspended.	High

MCO	Previous Review's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	address the following DHS-MCO contract requirement: ○ Ensure the appeal resolution letter includes a statement that the member may be held liable for the cost of continuing benefits during the State Fair Hearing process. - Incorporate a mechanism to address the DHS-MCO contract requirement to distribute the *Ombudsman Brochure* to providers at the time a contract is entered.	– The organization updated procedures to include the requirement that a member may be held liable for the cost of continuing benefits during the State Fair Hearing process. – Internal documentation was updated to include the timeframe by which the organization provides information about the grievance and appeal system to all providers and subcontractors, including the *Ombudsman Brochure.*	
UHC	– Update the provider notification process and related documents to ensure each provider receives the most recent copy of the *Ombudsman Brochure* and *Member Grievance and Appeals Guide* as required.	– The organization did not address the prior review's recommendation.	Low

Conclusions

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

Protocol 4: Validation of Network Adequacy

Validation of Network Adequacy, or Network Adequacy Validation (NAV), is a mandatory activity, identified in 42 CFR §438.68. The review assesses the capabilities of each managed care organization's provider network to ensure each are sufficient to provide timely and accessible care to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries across the continuum of services. 42 CFR §438.68 requires states to set quantitative network adequacy standards that account for regional factors and the needs of the state's managed care programs populations. This is a new protocol, implemented in calendar year 2024 (CY 2024).

MetaStar has partnered with Myers and Stauffer, a nationally-based certified public accounting and consulting firm, to conduct the validation of network adequacy. The firm works with states and specializes in Medicaid rate development, quality improvement consulting, auditing, data analysis, and data management.

As a guide for conducting the NAV, the *CMS External Quality Review (EQR) Protocols, Protocol 4: Validation of Network Adequacy* was used (February 2023). EQR Protocol 4 includes six activities:

- Activity 1: Define the Scope of Validation
- Activity 2: Identify Data Sources for Validation
- Activity 3: Review Information Systems Underlying Network Adequacy Monitoring (ISCA)
- Activity 4: Validate Network Adequacy Assessment Data, Methods, and Results
- Activity 5: Communicate Preliminary Findings to Each MCO
- Activity 6: Communicate Findings to State

Network adequacy standards are included by reference in each program's contract with the Wisconsin Department of Health Services (DHS). Through the process of preparing and conducting the review, a need to revise network adequacy standards was identified. As a result, the findings from the evaluation were not reflective of current network adequacy. The standards for evaluation have been updated, the review will be conducted in CY 2025, and those results will be included in the corresponding annual technical report.

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

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

The review focused on six categories to evaluate program compliance:

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

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

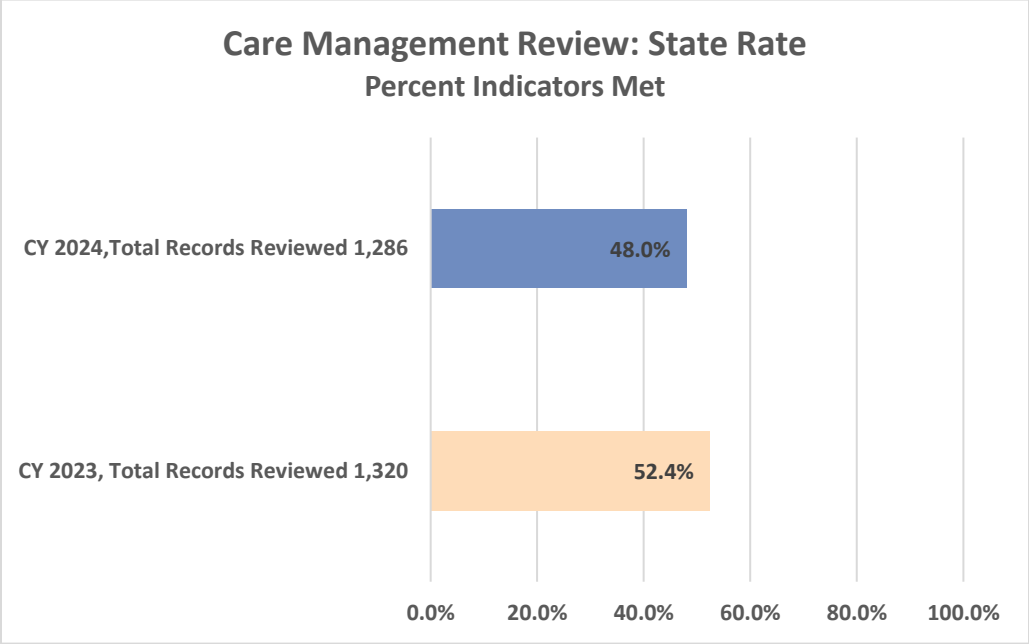
Validation of care management practices was conducted for the following organizations:

Organizations	Program(s)
Anthem Blue Cross and Blue Shield Health Plan (Anthem)	BC+ SSI
Group Health Cooperative of Eau Claire (GHC-EC)	BC+ SSI
Independent Care Health Plan (*i*Care)	BC+ SSI
MHS Health Wisconsin (MHS)	BC+ SSI

Organizations	Program(s)
Molina HealthCare of Wisconsin (MHWI)	BC+ SSI
Network Health Plan (NHP)	BC+ SSI
Quartz Health Solutions, Inc. (Quartz)	BC+ SSI
Security Health Plan of Wisconsin, Inc. (SHP)	BC+ SSI
United Healthcare Community Plan (UHC)	BC+ SSI

Overall Results

The following bar graph represents the overall percent of Care Management Review (CMR) standards met by the MCOs in CY 2024 and CY 2023 for all 16 review indicators. Additionally, Appendix 6 includes CY 2024 results for each indicator by MCO.



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 compares the CY 2024 and CY 2023 results for each of the review indicators comprising the CMR category. The notes below each bar graph specify the number of applicable records when it is less than the total number reviewed.

Screening

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

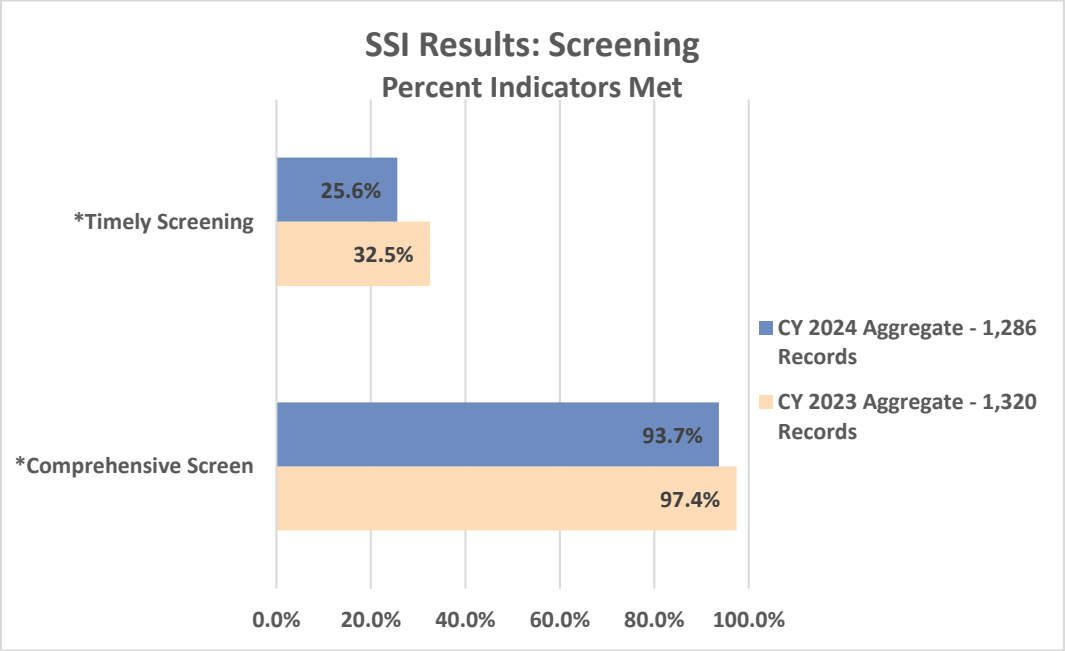
The initial screen and subsequent rescreens must meet the timelines and other requirements described in the DHS-MCO contract. The care management team must comprehensively screen each member and document information, such as:

- The member's chronic physical health needs (including dental);
- The member's chronic mental and behavioral health needs (including alcohol and other drug abuse);
- The member's perception of their strengths and general well-being;
- If the member has a usual source of care;
- Any indirect supports the member may have;
- Any relationships the member may have with community resources;
- Any immediate and/or long-term member concerns about their overall well-being including social determinants of health (SDOH);
- Activities of daily living needs (ADLs); and
- Instrumental activities of daily living needs (IADLs).

The indicator *Timely Screening* evaluated if screens were conducted within 60 days of member enrollment or re-enrollment and once every 12 months. If a member disenrolls during the review period and the member's screen was completed prior to the review period, the timeliness of the screen cannot be evaluated and that indicator will not be applicable. This indicator applied to 1,264 of 1,286 records. Results for the indicator declined from the prior year and indicated a need for improvement. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The most common reason screens were not timely was due to screens not updated once every 12 months for ongoing enrollees.

The indicator *Comprehensive Screen* ensured the MCOs evaluate member needs based on the DHS-MCO contract requirements. If a screen was not completed, then it cannot be evaluated for comprehensiveness and that indicator will not be applicable. This indicator applied to 495 of 1,286 records. Of the screens reviewed, 93.7 percent were comprehensive. Of all applicable assessment elements reviewed, 94.1 percent were found to be assessed. Results for the indicator declined from the prior year, however, continued to demonstrate strong practices.

Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The MCOs ensured most member screens were comprehensive.



*Note: The review indicator *Timely Screening* applied to 1,264 of 1,286 records in CY 2024 and 1,309 of 1,320 records in CY 2023. The review indicator *Comprehensive Screen* applied to 495 of 1,286 records in CY 2024 and 574 of 1,320 records in CY 2023.

Care Planning

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

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

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

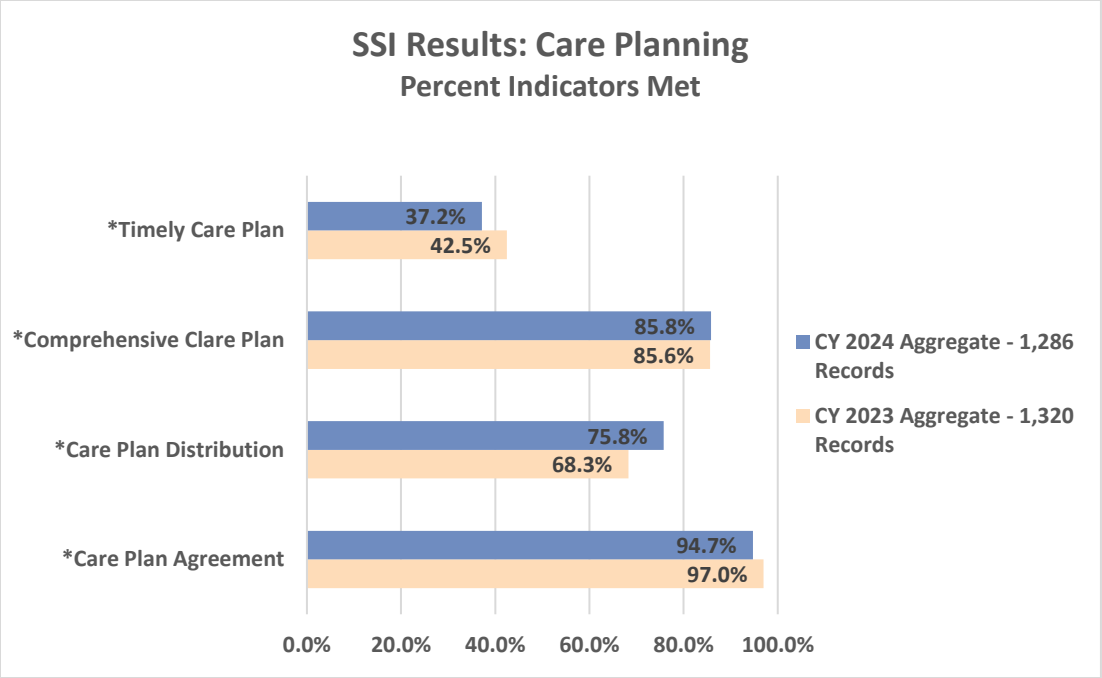
If the member does not have a care plan completed, then it cannot be evaluated for care plan comprehensiveness, distribution, and agreement; therefore, those indicators will not be applicable.

The indicator *Timely Care Plan* evaluated if care plans are completed within 30 days of the completed screen or 90 days after enrollment, whichever comes first. If a member does not have a care plan review due during the review period due to disenrollment, this indicator is not applicable. This indicator applied to 1,264 of 1,286 records. Results for the indicator declined from the prior year and demonstrated a need for improvement. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The majority of records unmet for this indicator did not include a care plan during the review period.

The indicator *Comprehensive Care Plan* ensured member care plans included all assessed needs. Of the records reviewed, 492 of 1,286 records demonstrated a completed care plan and were evaluated for comprehensiveness. Of the care plans reviewed, 85.8 percent were comprehensive. Of the required care plan elements, 87.5 percent were found to be included on the plan. Results for the indicator were similar to the prior year and demonstrated opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. The most common reason care plans were not comprehensive was the plans did not include the members dental care needs.

The indicator *Care Plan Distribution* evaluated if the care plan was shared with all required persons. Of the records reviewed, 492 of 1,286 records demonstrated a completed care plan to be distributed and were evaluated for distribution. Results for the indicator improved from the prior year; however, continued to demonstrate a need for improvement. Analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance. The majority of records not fully met for this indicator did not demonstrate that care plans were shared with the members' PCP, as a PCP was not identified.

The indicator *Care Plan Agreement* evaluated if the member agreed to the care plan prior to its implementation. Of the records reviewed, 492 of 1,286 records demonstrated a completed care plan that a member could agree to and were evaluated for agreement. Results for the indicator were similar to the prior year and indicated strengths. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Members agreed to care plans prior to implementation.



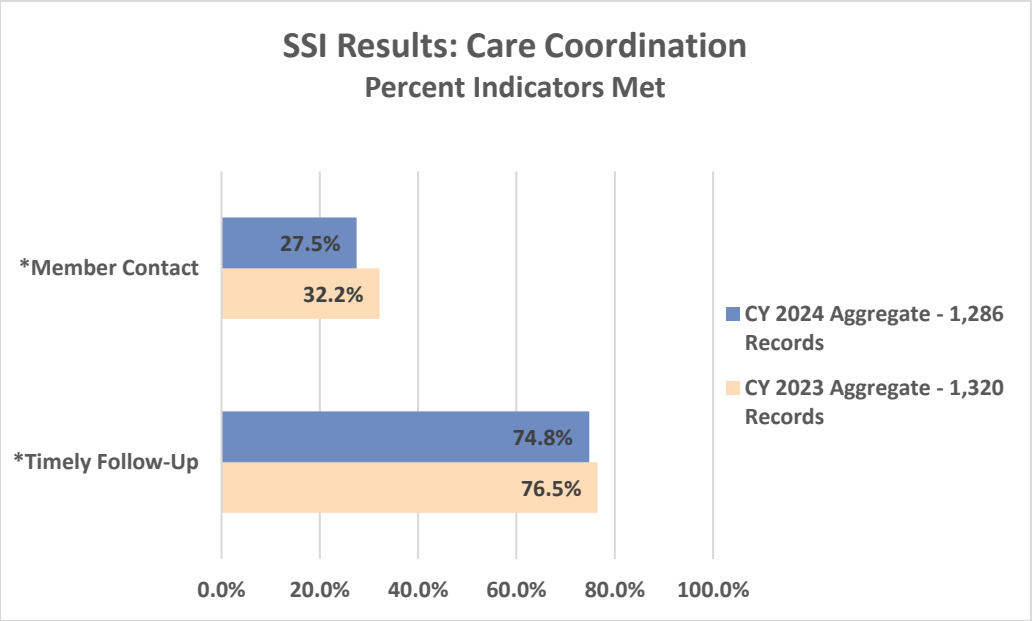
*Note: The review indicator *Timely Care Plan* applied to 1,264 of 1,286 records in CY 2024 and 1,307 of 1,320 records in CY 2023. The review indicator *Comprehensive Care Plan* applied to 492 of 1,286 records in CY 2024 and 571 of 1,320 records in CY 2023. The review indicator *Care Plan Distribution* applied to 492 of 1,286 records in CY 2024 and 571 of 1,320 records in CY 2023. The review indicator *Care Plan Agreement* applied to 492 of 1,286 records in CY 2024 and 571 of 1,320 records in CY 2023.

Care Coordination

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

The indicator *Member Contact* evaluated if the member was contacted once every 12 months or more frequently based on the member's needs and stratification level to ensure member health and safety. If a member was not enrolled during the entire review period and did not require annual contact, this indicator will not be applicable. Of the records reviewed 1,190 of 1,286 records required, at minimum, annual contact. Results for the indicator declined from the prior year and demonstrated a need for improvement. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The majority of records not fully met for this indicator demonstrated the MCOs' care management teams attempted to contact members at the designated timeframe based on stratification level; however, care teams were unable to connect with members.

The indicator *Timely Follow-Up* evaluated if the care management team followed up with members to confirm if identified needs or requests were addressed. If the member did not have identified follow-up needs during the review period, this indicator was not applicable. Of the records reviewed, 353 included a follow-up need and 74.8 percent demonstrated timely follow-up in all instances when required. Of the instances a member required care management follow-up, 81.9 percent received follow-up. Results for the indicator were similar to the prior year and demonstrated opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Records found unmet for this indicator were due to a lack of documented follow-up for members' physical health needs.



*Note: The review indicator *Member Contact* applied to 1,190 of 1,286 records in CY 2024 and 1,286 of 1,320 records in CY 2023. The review indicator *Timely Follow-Up* applied to 353 of 1,286 records in CY 2024 and 422 of 1,320 records in CY 2023.

Care Plan Review and Update

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

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

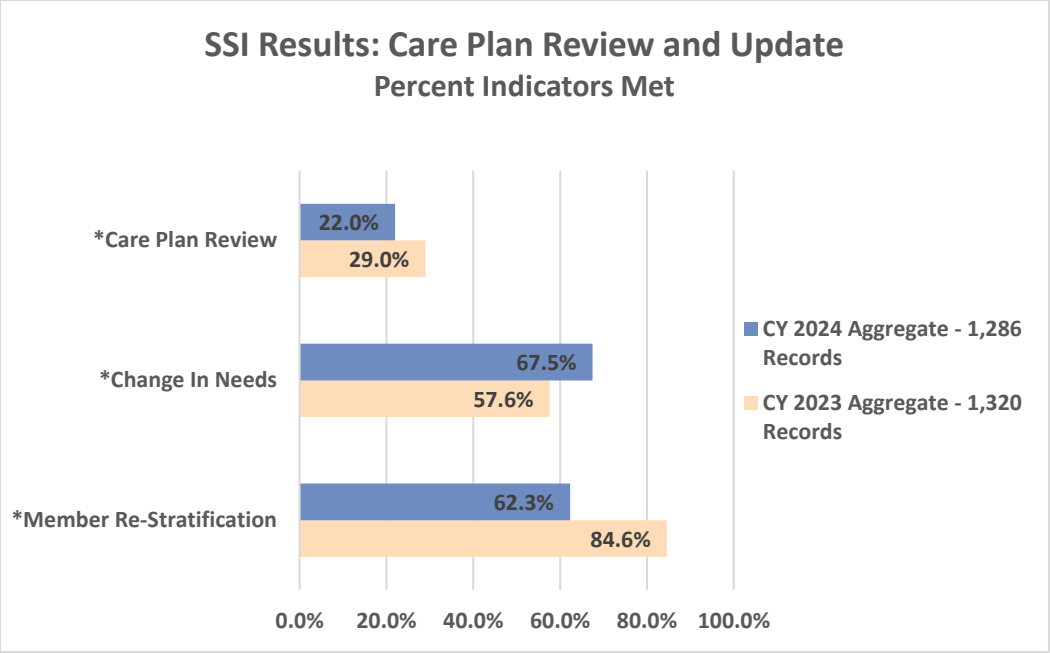
- Member request or identification of a problem/gap not previously addressed.

The indicator *Care Plan Review* evaluated if the care plan was reviewed at least once every 12 months. If a member newly enrolls in the SSI program during the review period, an annual care plan review is not expected. Of the records reviewed, 999 of 1,286 records required a care plan review every 12 months. Results for the indicator declined from the prior year and indicated a need for improvement. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. In most cases, the current care plans were not found.

The indicator *Change in Needs* evaluated whether the care management team updated the care plan when there was a change in member needs. If a member does not have changes in needs that require a care plan update during the review period, this indicator is not applicable. Of the records reviewed, 80 required a care plan update. Of those 80 records, 67.5 percent were updated for all instances. Of all instances that required a care plan update, 63.9 were updated. Results for the indicator were similar to the prior year and demonstrated opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Records found unmet for this indicator did not include an updated care plan for frequent transitions between care settings.

The indicator *Member Re-Stratification* evaluated if the member was re-stratified after a critical event. Of the records reviewed, 159 of 1,286 records indicated the need for re-stratification.

Results for the indicator declined from the prior year and indicated a need for improvement. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. Most records did not indicate re-stratification after a critical event.



*Note: The review indicator *Care Plan Review* applied to 999 of 1,286 records in 2024 and 1,127 of 1,320 records in CY 2023. The review indicator *Change in Needs* applied to 80 of 1,286 records in CY 2024 and 66 of 1,320 records in CY 2023. The review indicator *Member Re-Stratification* applied to 159 of 1,286 records in CY 2024 and 78 of 1,320 records in CY 2023.

Transition Planning

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

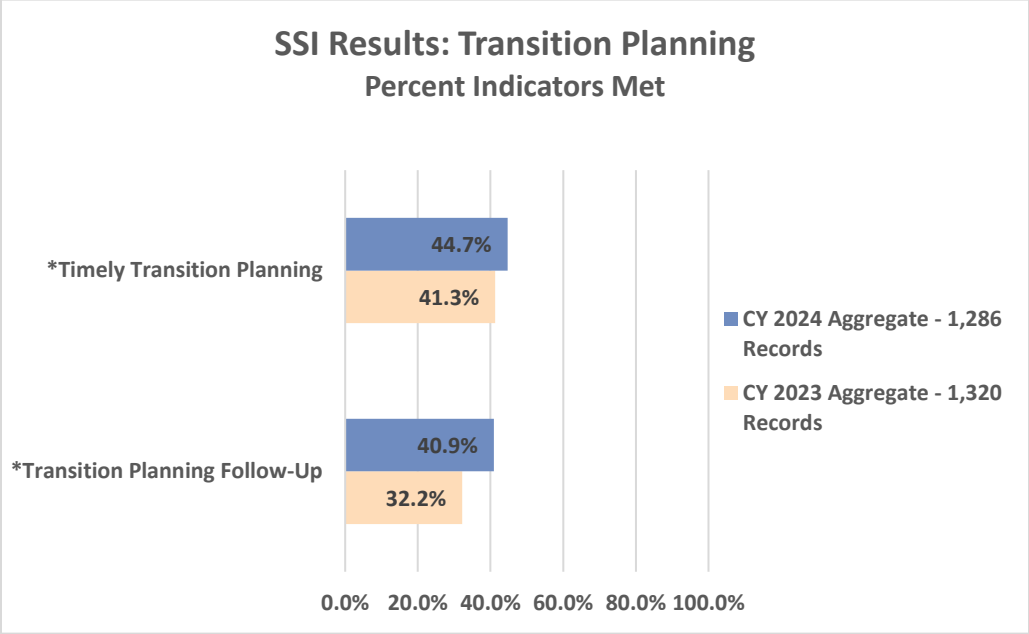
- Conduct a medication reconciliation (or confirm the hospital completed);
- Evaluation of the member's ability to manage their medications;
- Help the member understand their medication and medication schedule, their treatment or discharge plan, and how to best manage their conditions.

If a member does not have any hospitalizations during the review period, this section was not applicable. Of the records reviewed, 132 of 1,286 records indicated a member hospitalization during the review period.

The indicator *Timely Transition Planning* ensured the member was contacted timely by the care management team after discharge from an inpatient hospital facility. Results for the indicator were similar to the prior year and demonstrated a need for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Records

found unmet for this indicator did not demonstrate members were contacted within five business days of discharge from an inpatient setting.

The indicator *Transition Planning Follow-Up* ensured the care management team conducted all follow-up activities with the member after discharge from an inpatient hospital facility. Results for the indicator were similar to the prior year and indicated a need for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Records found unmet for this indicator did not demonstrate the care management teams reviewed all required hospital discharge information when contacting members within five business days of hospital discharge.



*Note: The review indicator *Timely Transition Planning* applied to 132 of 1,286 records in CY 2024 and 143 of 1,320 records in CY 2023. The review indicator *Transition Planning Follow-Up* applied to 132 of 1,286 records in CY 2024 and 143 of 1,320 records in CY 2023.

Wisconsin Interdisciplinary Care Team

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

- At least two licensed health care professionals (with access to multiple disciplines);
- Weekly WICT Core Team meetings to discuss the entirety of their shared caseload; and

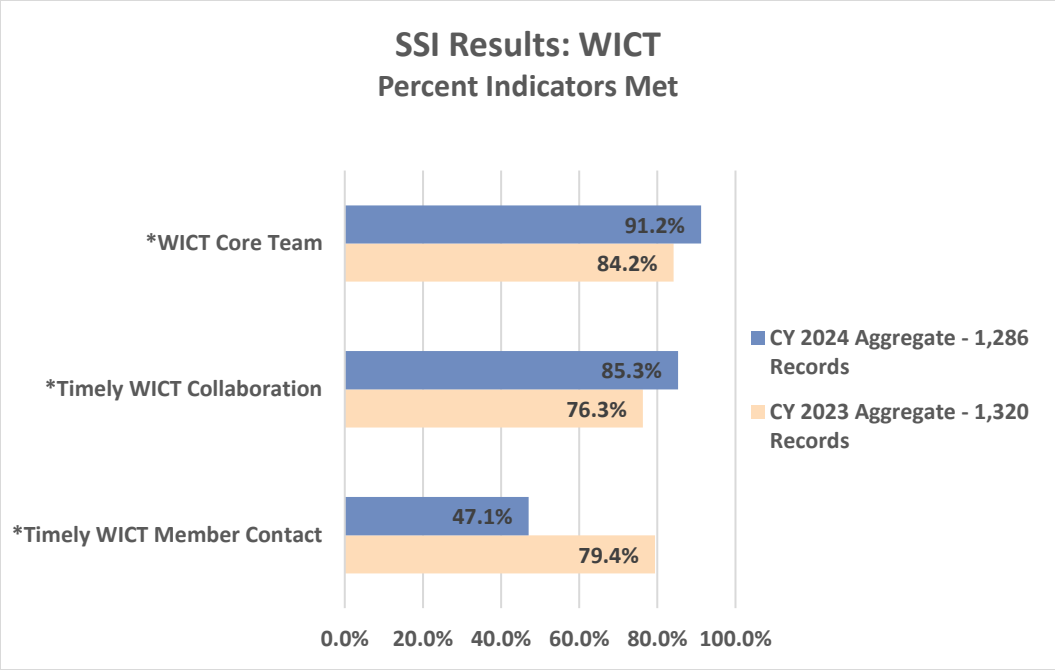
- A monthly face-to-face meeting between a member of the WICT Core Team and the member.

If a member is not stratified as WICT during the review period, this section will not apply. Of the records reviewed, 34 of 1,286 members were re-stratified as WICT at least once during the review period.

The indicator *WICT Core Team* ensured the care management team includes two licensed professionals. Results for the indicator were similar to the prior year and demonstrated strengths. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. The MCOs ensured the majority of WICT Core Teams included at least two licensed professionals.

The indicator *Timely WICT Collaboration* ensured the WICT Core Team meet at least weekly to discuss the member's needs and care. Results for the indicator were similar to the prior year and demonstrated opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Records found unmet for this indicator did not demonstrate the WICT Core Teams met at least weekly to discuss members.

The indicator *Timely WICT Member Contact* ensured the WICT Core Team meets with the member, face-to-face, at least monthly. Results for the indicator declined from the prior year and indicated a need for improvement. During the previous year's review, face-to-face requirements were waived due to the Coronavirus Disease 2019 (COVID-19) global pandemic, which likely attributed to the decline in rates. Records found unmet for this indicator did not evidence the WICT Core Teams met face-to-face once a month with members.



*Note: The review indicator *WICT Core Team* applied to 34 of 1,286 records in CY 2024 and 38 of 1,320 records in CY 2023. The review indicator WICT Core Team Collaboration applied to 34 of 1,286 records in CY 2024 and 38 of 1,320 records in CY2023. The review indicator WICT Core Team Member Contact applied to 17 of 1,286 records in CY 2024 and 34 of 1,320 records in CY 2023.

Progress on Previous EQRO Plan Level Recommendations

MetaStar assessed the degree that each MCO effectively addressed recommendations for quality improvement made by the EQRO during the previous year's EQR. The following rating scale was applied to each MCO.

Degree to Which the MCO Addressed the Recommendations	
High	The MCO addressed all recommendations.
Medium	The MCO addressed more than half of the recommendations, but not all.
Low	The MCO addressed less than half of the recommendations.

The table below identifies the recommendations made the by the EQRO in the prior review, CY 2023, the actions taken by the MCO to address the recommendations, and the degree to which the MCO addressed the recommendations.

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Anthem	– Complete member screens timely. – Focus efforts on improving timeliness on completion of member care plans. – Ensure care plans are comprehensive. – Ensure care plans are shared with all required persons. – Prioritize efforts on contacting members based on their needs and stratification level. – Provide timely follow-up to member needs, specifically for physical health needs. – Review care plans at least once every 12 months. – Ensure care plans are updated for changing member needs. – Ensure members are re-stratified after a critical event. – Contact members within five business days of discharge from an inpatient facility. – Provide follow-up after hospitalization discharge to members.	– The organization did not address the prior review's recommendations.	Low
GHC-EC	– Complete member screens timely. – Ensure care plans are completed within the required timeframe. – Focus efforts on care plans to include all required elements. – Ensure care plan are shared with all required individuals. – Prioritize efforts on contacting members based on their needs and stratification level. – Provide timely follow-up for member needs and requests.	– The organization did not address the prior review's recommendations.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Review care plans at least once every 12 months. – Contact members within five business days of discharge from an inpatient facility. – Provide follow-up after hospitalization discharge. – Ensure the Wisconsin Interdisciplinary Core Team meets weekly to discuss the member.		
*i*Care	– Complete member screens timely. – Complete care plans timely. – Ensure care plans include all required elements. – Share care plans with all required individuals. – Ensure members are contacted based on needs and stratification level. – Conduct timely follow-up for member needs and requests. – Complete care plan reviews at least once every 12 months. – Update care plans for changing member needs. – Contact members within five business days of discharge from an inpatient hospital facility. – Ensure transition care follow-up includes the review of hospital discharge information with the member. – Ensure the Wisconsin Interdisciplinary Core Team includes two licensed health care providers. – Ensure the Wisconsin Interdisciplinary Core Team meets weekly to discuss the member.	– The organization did not address the prior review's recommendations.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Conduct monthly face-to-face meetings between at least one member of the Wisconsin Disciplinary Core Team and the member.		
MHS	– Complete member screens timely. – Complete care plans timely. – Share care plans with all required individuals. – Complete care plan reviews at least once every 12 months. – Contact members within five business days of discharge from an inpatient hospital facility. – Ensure transition care follow-up includes the review of hospital discharge information with the member. – Ensure the Wisconsin Interdisciplinary Core Team includes two licensed health care providers. – Ensure the Wisconsin Interdisciplinary Core Team meets weekly to discuss the member. – Conduct monthly face-to-face meetings between at least one member of the Wisconsin Disciplinary Core Team and the member.	– The organization did not address the prior review's recommendations.	Low
MHWI	– Complete member screens timely. – Focus efforts on improving timeliness of completion of member care plans. – Develop comprehensive care plans that include all required elements. – Ensure care plans are shared with all required individuals.	– The organization ensured member care plans were comprehensive.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Prioritize efforts on contacting members based on their needs and stratification level. – Provide timely follow-up to member needs, specifically for physical health needs. – Review care plans at least once every 12 months. – Contact members within five business days of discharge from an inpatient hospital facility. – Ensure transition care follow-up includes the review of hospital discharge information with the member.		
NHP	– Complete member screens timely. – Focus efforts on improving timeliness on completion of member care plans. – Ensure care plans are shared with all required individuals. – Prioritize efforts on contacting members based on their needs and stratification level. – Provide timely follow-up to member needs, specifically for physical health needs. – Review care plans at least once every 12 months. – Contact members within five business days of discharge from an inpatient hospital facility. – Ensure transition care follow-up includes the review of hospital discharge information with the member.	– The organization did not address the prior review's recommendations.	Low
Quartz	– Ensure member screens are completed within 60 days of the member's enrollment.	– The organization conducted timely follow-up for member needs and requests.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Ensure member screens include all required assessment elements. – Complete member care plans timely. – Ensure the care plan includes all required elements. – Share the care plan with all required individuals. – Ensure the member agrees to the care plan prior to implementation. – Contact and connect with members based on members' needs and stratification level. – Conduct timely follow-up for all member needs and requests.		
SHP	– Ensure member screens are completed timely. – Focus efforts on member care plans to improve timeliness of completion. – Ensure care plans are comprehensive. – Share care plans with all required individuals. – Focus efforts on contacting members based on their needs and stratifications levels. – Ensure timely follow-up to member needs, specifically for physical health needs. – Update care plans for changing member needs. – Re-stratify members after a critical event. – Provide timely contact to members after hospital discharge. – Provide hospital discharge follow-up to members.	– The organization ensured care plans were comprehensive. – The organization improved efforts to contact members at their assigned stratification level.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
UHC	– Complete member screens timely. – Complete care plans timely. – Share care plans with all required individuals. – Ensure members are contacted based on needs and stratification level. – Conduct timely follow-up for member needs and requests. – Complete care plan reviews at least once every 12 months. – Update care plans for changing member needs. – Contact members within five business days of discharge from an inpatient hospital facility. – Ensure transition care follow-up includes the review of hospital discharge information with the member.	– The organization ensured care plans were updated for changing member needs.	Low

Conclusions

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

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

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

The review focused on five categories to evaluate program compliance:

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

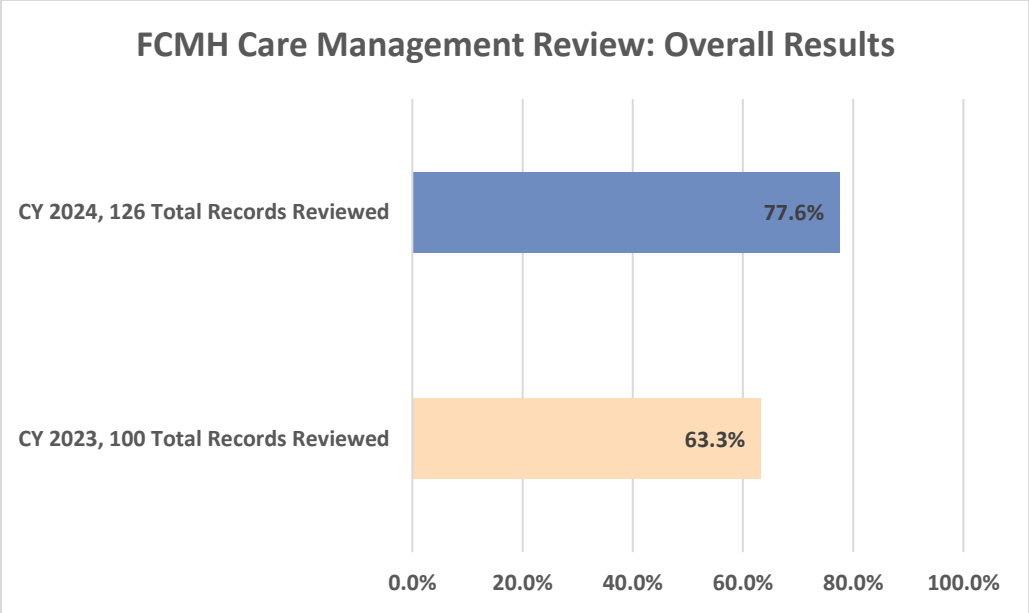
The five categories included a total of 14 review indicators. More information about the review methodology can be found in Appendix 2.

Validation of care management practices was conducted for the following organization:

Organization	Program(s)
Chorus Community Health Plan, Inc. (CCHP)	FCMH

Overall Results

The following bar graph represents the overall percent of Care Management Review (CMR) standards met by the PIHP in CY 2024 and CY 2023 for all 14 review indicators. Following the CY 2023 review, changes were made to the scoring criteria for the indicators in the *Transition Planning* section, making the overall results not comparable to results from the previous year. Results from prior years will be included for the overall results and all indicators as a reference and narrative explanation will be included with details on changes or lack of comparability.



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.

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 represents the PIHP's CY 2024 and CY 2023 results for each of the review indicators comprising the CMR category. The notes below each bar graph specify the number of applicable records when it is less than the total number reviewed.

Screening

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

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

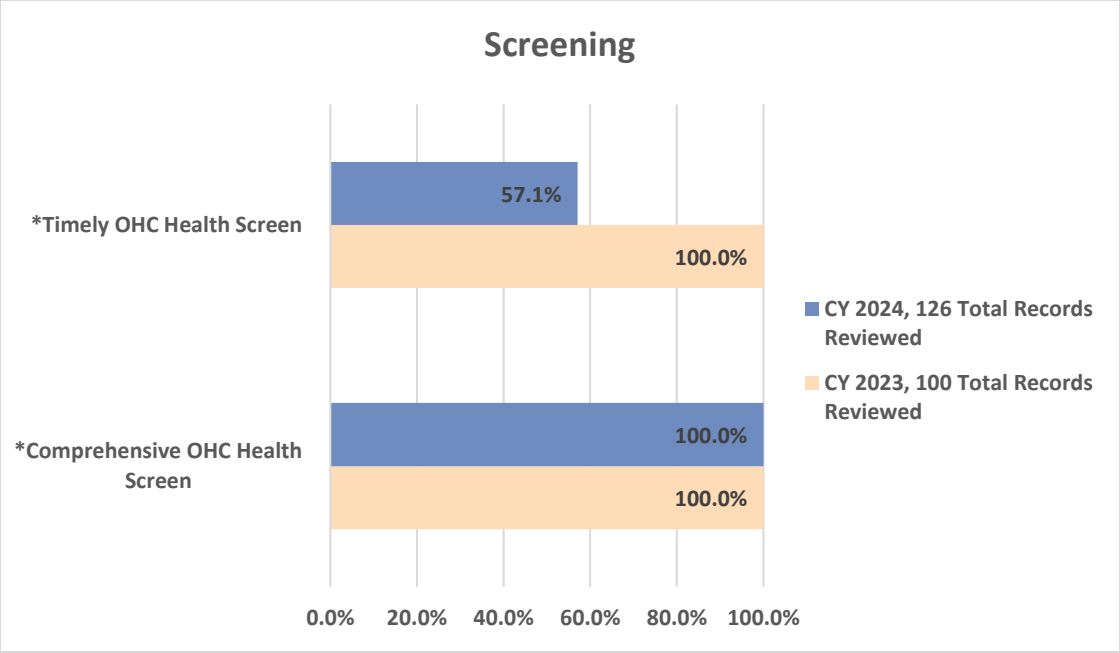
Members may be exempt from the OHC Health Screen. The PIHP is not required to complete the screen under the following circumstances:

- Newborns detained directly from the hospital;
- Children detained during an inpatient hospitalization;
- Children who are detained at the time of a forensic exam;
- Children who are detained subsequent to a forensic exam but meet the criteria for an exemption; or
- Other unique case scenarios may be reviewed by the Care4Kids Medical Director(s) and exemptions may be granted on a case by case basis if performing the Out-of-Home Care Health Screen would be duplicative of services recently provided.

The section *Screening* is only applicable to members who newly enrolled in the C4K program during the review period. The *Screening* section applied to seven of 126 records reviewed. Of the records reviewed, two records were exempt from the OHC Health Screen. The most common exemption included newborns detained directly from the hospital.

The indicator *Timely OHC Health Screen* ensured the OHC Health Screen was completed within two business days of entry into out-of-home care. Results for the indicator were similar to the prior year and demonstrated opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Approximately half of the records unmet for this indicator did not complete OHC Screens within two business days of out-of-home placement.

The indicator *Comprehensive OHC Health Screen* ensured the OHC Health Screen was comprehensive. Results for the indicator were similar to the prior review and indicated strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. The organization ensured all required elements of the OHC health screen were assessed.



*Note: The review indicators *Timely OHC Health Screen* applied to 7 of 126 records in CY 2024 and 10 of 100 records in CY 2023. The review indicator *Comprehensive OHC Health Screen* applied to 6 of 126 records in CY 2024 and 10 of 100 in CY 2023.

Assessment

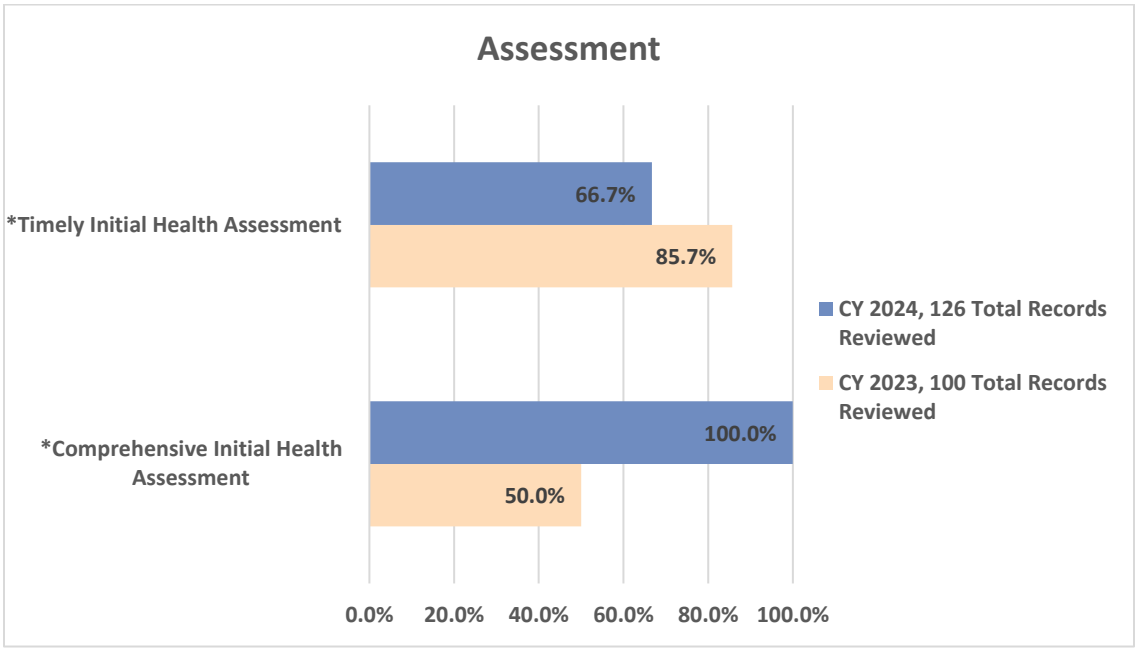
The initial health assessment must be completed within 30 calendar days of enrollment. The assessment must include the review of the member's physical health, behavioral health, oral health, and developmental problems.

The section *Assessment* is only applicable to members who newly enrolled in the C4K program during the review period. This section applied to nine of 126 records reviewed.

The indicator *Timely Initial Health Assessment* ensured the initial health assessment was completed within 30 days of enrollment. Results for the indicator were similar to the prior review and demonstrated opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Half of the records unmet for this indicator did not complete the initial health assessment within 30 days of enrollment.

The indicator *Comprehensive Initial Health Assessment* ensured the OHC Health Screen was comprehensive. Results for the indicator improved from the prior review and demonstrated strong practices. Analysis indicated the year-to-year difference in the rates is likely attributable to actions of the PIHP, and is unlikely to be the result of normal variation or chance. The

organization demonstrated strong practices to ensure initial health assessments were comprehensive.



*Note: The review indicators *Timely Initial Health Assessment* applied to 9 of 126 records in CY 2024 and 14 of 100 in CY 2023. The review indicator *Comprehensive Initial Health Assessment* applied to 8 of 126 records in CY 2024 and 12 of 100 in CY 2023.

Care Planning

The initial care plan must be completed within the first 60 calendar days of enrollment. Ongoing care plans must be reviewed and updated at least once every six months, when indicated, and within 30 days of discharge from an inpatient mental health hospitalization. The care plan review must include the 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.

The indicator *Timely Initial Care Plan* ensures the initial care plan was developed within 60 days of enrollment. Results for the indicator were similar to the prior review and indicated strengths. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. The organization ensured initial care plans were completed within 60 days of enrollment.

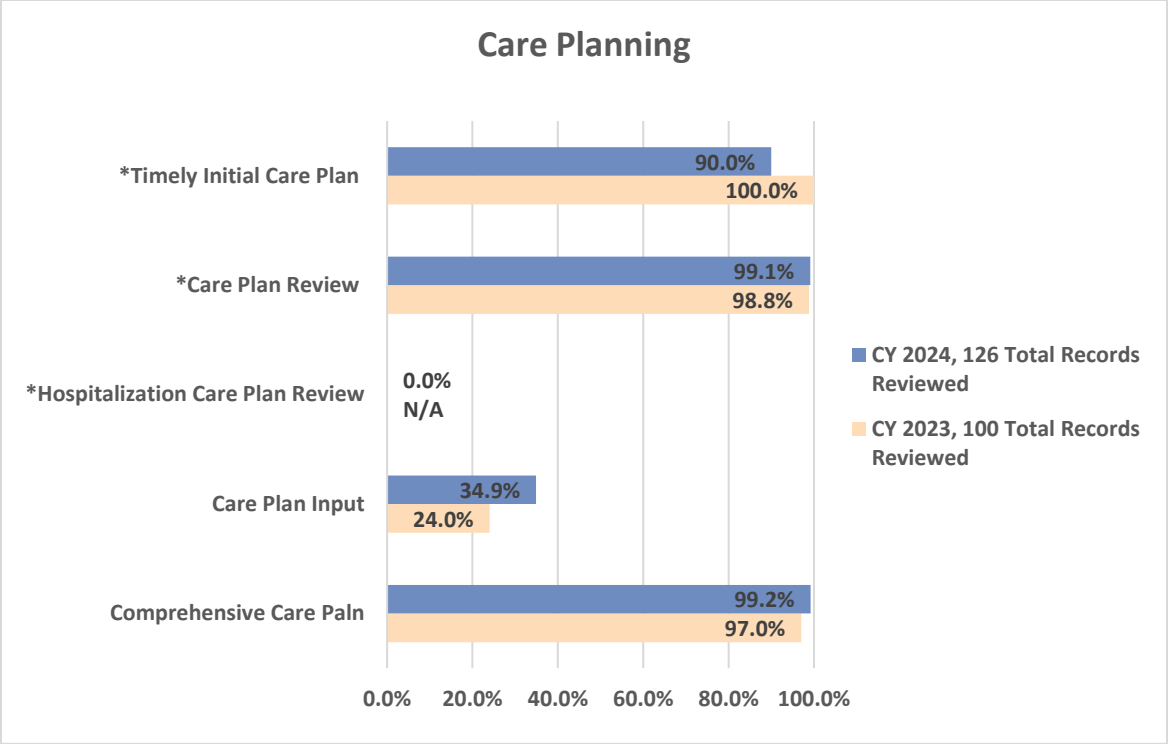
The indicator *Care Plan Review* ensures the care plan was reviewed and updated at least once every six months or when indicated. Results for the indicator were similar to the prior review

and indicated strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. The organization demonstrated strong practices of ongoing care plan reviews, ensuring care plans were reviewed once every six months and updated when indicated.

The indicator *Hospitalization Care Plan Review* ensures the care plan was reviewed and updated within 30 days of discharge from an inpatient mental health hospitalization. Two of 126 members were hospitalized for mental health needs during the review period. The majority of the records unmet for this indicator did not evidence care plan reviews within 30 days of discharge from an inpatient mental health facility.

The indicator *Care Plan Input* ensures the most recent care plan evaluated during the review period included input from all required individuals. Results for the indicator were similar to the prior review and indicated a need for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. The majority of the records unmet for this indicator did not evidence care plan input from the parent/legal guardian.

The indicator *Comprehensive Care Plan* ensures the most recent care plan was comprehensive. Results for the indicator were similar to the prior review and demonstrated strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. The organization developed comprehensive care plans.

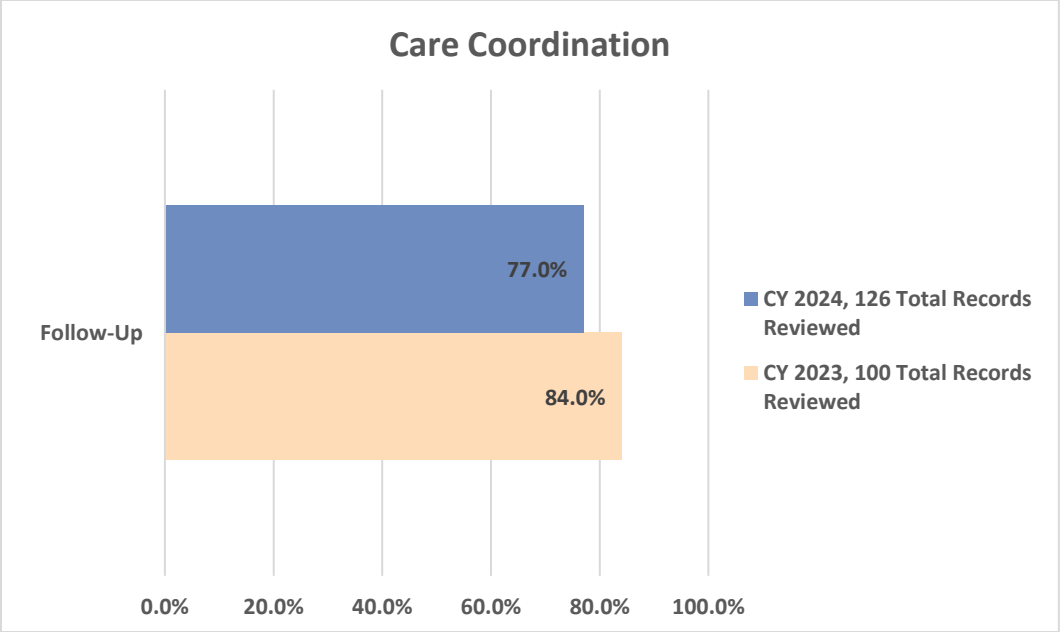


*Note: The review indicators *Timely Initial Care Plan* applied to 10 of 126 records in CY 2024 and 16 of 100 in CY 2023. The review indicator *Care Plan Review* applied to 111 of 126 records in CY 2024 and 81 of 100 in CY 2023. The review indicator *Hospitalization Care Plan Review* applied to 2 of 126 records in CY 2024 and no records in CY 2023.

Care Coordination

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

The indicator *Follow-Up* ensures ongoing and timely monitoring and follow-up of the member's needs and services. Results for the indicator were similar to the prior review and demonstrated opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. The majority of the records unmet for this indicator did not evidence timely follow-up for needs identified during the OHC Health Screen process. Follow-up for the member's physical health needs was the most common reason this indicator was not met.



Transition Planning

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

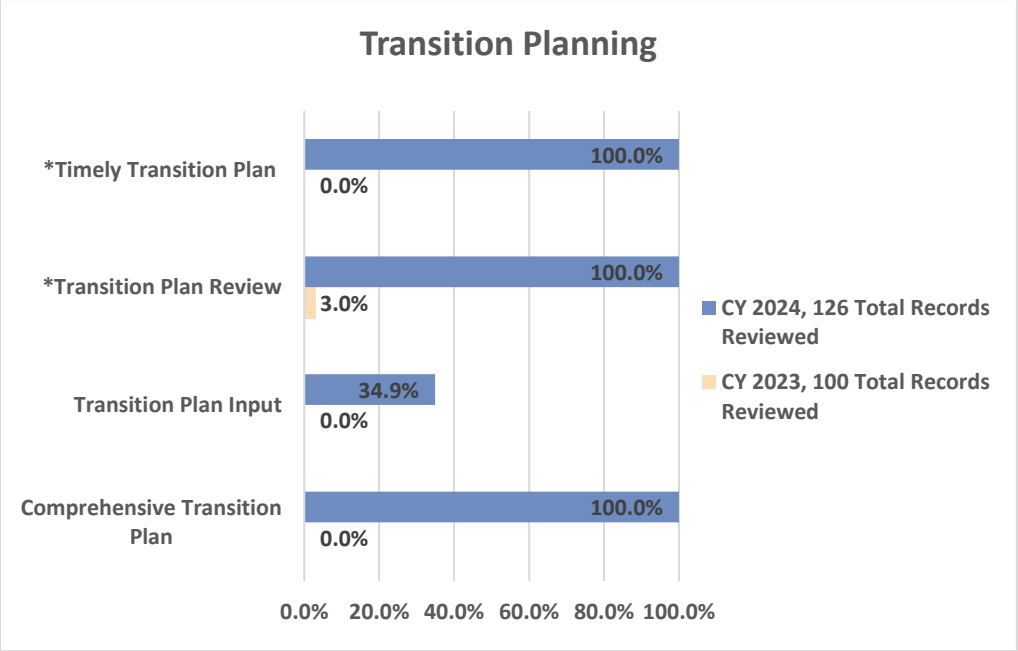
Following the CY 2023 review, changes were made to the scoring criteria for the indicators in the *Transition Planning* section, making the *Transition Planning* section results not comparable to results from the previous year.

The indicator *Timely Transition Plan* ensured the initial transition plan was created timely. Results for the indicator demonstrated strong practices. Transition plans were created timely.

The indicator *Transition Plan Review* ensured the transition plan was reviewed and updated at least once every six months. Results for the indicator demonstrated strong practices. Transition plans were reviewed and updated timely.

The indicator *Transition Plan Input* ensured the most recent transition plan reviewed during the review period included input from the required individuals. Results for the indicator demonstrated a need for improvement. Most transition plans did not include input from the parent/legal guardian.

The indicator *Comprehensive Transition Plan* ensured the most recent transition plan reviewed during the during period was comprehensive. Results for the indicator demonstrated strong practices. Transition plans were comprehensive.



*Note: The review indicators *Timely Transition Plan* applied to 16 of 126 records in CY 2024 and 51 of 100 in CY 2023. The review indicator *Transition Plan Review* applied to 110 of 126 records in CY 2024 and 33 of 100 in CY 2023.

Progress on Previous EQRO Plan Level Recommendations

MetaStar assessed the degree that each MCO effectively addressed recommendations for quality improvement made by the EQRO during the previous year's EQR. The following rating scale was applied to each MCO.

Degree to Which the MCO Addressed the Recommendations	
High	The MCO addressed all recommendations.
Medium	The MCO addressed more than half of the recommendations, but not all.
Low	The MCO addressed less than half of the recommendations.

The following table identifies the recommendations made the by the EQRO in the prior review, CY 2023, the actions taken by the MCO to address the recommendations, and the degree to which the MCO addressed the recommendations.

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCHP	– Conduct initial health assessments timely. – Ensure the initial health assessment is comprehensive. – Include input from all required individuals into each care plan review. – Complete timely follow-up for member needs and services. – Ensure transition plans are created timely. – Ensure transition plans are reviewed and updated timely. – Include input from all required individuals into each transition plan review. – Ensure transition plans are comprehensive.	– The organization ensured initial health assessments were comprehensive. – *The organization ensured transition plans were created timely. – *The organization demonstrated transition plans were reviewed and updated timely. – *The organization ensured transition plans were comprehensive.	Medium

* Following the CY 2023 review, changes were made to the scoring criteria for the indicators in the *Transition Planning* section, making the *Transition Planning* section results not comparable to results from the previous year.

Conclusions

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

Appendix A: Information Systems Capabilities Assessment

The information systems capabilities assessment (ISCA) is a required part of other mandatory EQR protocols, such as Compliance with Standards and Performance Measure Validation (PMV), and the review helps determine whether Managed Care Organizations' (MCOs') information systems (IS) are capable of collecting, analyzing, integrating, and reporting data. ISCA requirements are detailed in 42 Code of Federal Regulations (CFR) §438.242, the Wisconsin Department of Health Services (DHS) contract with the MCOs, 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 at least every three years.

Each organization's annual Healthcare Effectiveness Data and Information Set (HEDIS®) audit, as well as the plan's ability to report HEDIS® measures encompass the ISCA requirements. For organizations not evaluated by a National Committee for Quality Assurance (NCQA) certified HEDIS® Licensed Organization (LO), MetaStar conducts a full ISCA review.

A copy of each plan's Final Audit Report (FAR) was obtained to confirm compliance. Please refer to Appendix 2 for additional information regarding the reviews.

Validation of information systems was conducted for the following organizations in measurement year (MY) 2023:

Organizations	Program(s)	HEDIS® Compliance Audit™
Anthem Blue Cross and Blue Shield Health Plan (Anthem)	BC+ SSI	HEDIS® LO: Attest Health Care Advisors FAR Date: July 15, 2024
Children's Community Health Plan, Inc. (CCHP)	BC+ FCMH	HEDIS® LO: HealthcareData Company, LLC FAR Date: July 13, 2024
Dean Health Plan, Inc. (DHP)	BC+	HEDIS® LO: HealthcareData Company, LLC FAR Date: July 13, 2024
Group Health Cooperative of Eau Claire (GHC-EC)	BC+ SSI	HEDIS® LO: HealthcareData Company, LLC FAR Date: July 1, 2024
Group Health Cooperative of South-Central Wisconsin (GHC-SCW)	BC+	HEDIS® LO: Advent Advisory Group FAR Date: June 5, 2024
Independent Care Health Plan (*i*Care)	BC+ SSI	HEDIS® LO: Dunwoody Technology Services Group, LLC FAR Date: July 15, 2024
MercyCare Health Plans (MCHP)	BC+	HEDIS® LO: Health Services Advisory Group FAR Date: July 10, 2024
MHS Health Wisconsin (MHS)	BC+ SSI	HEDIS® LO: Attest Health Care Advisors FAR Date: July 15, 2024

Organizations	Program(s)	HEDIS® Compliance Audit™
Molina HealthCare of Wisconsin (MHWI) *My Choice Wisconsin was acquired by Molina HealthCare of Wisconsin in CY 2023.*	BC+ SSI	HEDIS® LO: Advent Advisory Group FAR Date: June 20, 2024
Network Health Plan (NHP)	BC+ SSI	HEDIS® LO: Attest Health Care Advisors FAR Date: July 15, 2024
Quartz Health Solutions, Inc. (Quartz)	BC+ SSI	HEDIS® LO: Advent Advisory Group FAR Date: June 20, 2024
Security Health Plan of Wisconsin, Inc. (SHP)	BC+ SSI	HEDIS® LO: HealthcareData Company, LLC FAR Date: July 13, 2024
United Healthcare Community Plan (UHC)	BC+ SSI	HEDIS® LO: Attest Health Care Advisors FAR Date: July 15, 2024
Wraparound Milwaukee	Children with mental health needs.	The organization received a full ISCA review in calendar year (CY) 2021. The organization ceased program operations in CY 2024.

Results

BadgerCare Plus (BC+) and Supplemental Security Income (SSI) Medicaid managed care programs that are accredited through the NCQA Health Plan Accreditation receive an annual compliance audit conducted by a NCQA certified HEDIS® LO.

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

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

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

IS Requirement Standards		
IS R	Data Management and Reporting (formerly IS 6.0, 7.0)	5 Standards
IS C	Clinical and Care Delivery Data (formerly IS 5.0)	4 Standards
IS M	Medical Record Review Processes (formerly IS 4.0)	5 Standards
IS A	Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)	3 Standards

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

Scoring Legend	
Met	The organization met all requirements.
Partially Met	The organization met most requirements.
Not Met	The organization did not meet requirements.

CY 2024 ISCA Results				
MCO	**IS R**	**IS C**	**IS M**	**IS A**
Anthem	Met	Met	Met	Met
CCHP	Met	Met	Met	Met
DHP	Met	Met	Met	Met
GHC-EC	Met	Met	Met	Met
GHC-SCW	Met	Met	Met	Met
iCare	Met	Met	Met	Met
MCHP	Met	Met	Met	Met
MHS	Met	Met	Met	Met
MHWI	Met	Met	Met	Met
NHP	Met	Met	Met	Met
Quartz	Met	Met	Met	Met
SHP	Met	Met	Met	Met
UHC	Met	Met	Met	Met

Observation and Analysis

All organizations fully met requirements for each of the four IS categories. The organizations demonstrated compliance with requirements for information systems capabilities.

Progress on Previous EQRO Plan Level Recommendations

MetaStar assessed the degree that each MCO effectively addressed recommendations for quality improvement made by the EQRO during the previous year's EQR. The following rating scale was applied to each MCO.

Degree to Which the MCO Addressed the Recommendations	
High	The MCO addressed all recommendations.
Medium	The MCO addressed more than half of the recommendations, but not all.

Degree to Which the MCO Addressed the Recommendations	
Low	The MCO addressed less than half of the recommendations.

The following table identifies the recommendations made the by the EQRO in the prior review, CY 2023, the actions taken by the MCO to address the recommendations, and the degree to which the MCO addressed the recommendations.

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Anthem	The organization fully met all requirements. No recommendations were identified.	The organization fully met all requirements.	N/A
CCHP	The organization fully met all requirements. No recommendations were identified.	The organization fully met all requirements.	N/A
DHP	The organization fully met all requirements. No recommendations were identified.	The organization fully met all requirements.	N/A
GHC-EC	– Continue collaborative efforts between the information technology and claims department to increase the claims auto-adjudication rate.	– The organization demonstrated efforts between the information technology and claims department to increase the claims auto-adjudication rate.	High
GHC-SCW	The organization fully met all requirements. No recommendations were identified.	The organization fully met all requirements.	N/A
*i*Care	– Continue to monitor claims from the third-party vision vendor to ensure completeness of data in the encounter submission files.	– The organization monitored claims from the third-party vision vendor to ensure completeness of data in the encounter submission files.	High
MCHP	The organization fully met all requirements. No recommendations were identified.	The organization fully met all requirements.	N/A
MHS	– Demonstrate effective procedures for submitting measure-relevant information for data entry, including checking procedures for	– The organization demonstrated effective procedures for submitting measure-relevant information for data entry,	High

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	electronic transmissions to ensure accuracy. – Perform consistent oversight and validation of vendors to ensure vendors meet expected performance standards. – Identify and correct incorrect extraction of data fields and delays in recognizing and/or remediating the underlying issues. – Identify and correct issues and delays related to improper identification of populations, utilization data extracts, measure report set selection.	including checking procedures for electronic transmissions to ensure accuracy. – The organization performed consistent oversight and validation of vendors to ensure vendors meet expected performance standards. – The organization identified and corrected incorrect extraction of data fields and delays in recognizing and/or remediating the underlying issues. – The organization identified and corrected issues and delays related to improper identification of populations, utilization data extracts, measure report set selection.	
MHWI	The organization fully met all requirements. No recommendations were identified.	The organization fully met all requirements.	N/A
NHP	– Demonstrate effective procedures for submitting measure-relevant information for data entry, including checking procedures for electronic transmissions to ensure accuracy. – Perform consistent oversight and validation of vendors to ensure vendors meet expected performance standards. – Identify and correct incorrect extraction of data fields and delays in recognizing and/or remediating the underlying issues. – Identify and correct issues and delays related to improper identification of populations, utilization data extracts, measure report set selection.	– The organization demonstrated effective procedures for submitting measure-relevant information for data entry, including checking procedures for electronic transmissions to ensure accuracy. – The organization performed consistent oversight and validation of vendors to ensure vendors meet expected performance standards. – The organization identified and corrected incorrect extraction of data fields and delays in recognizing and/or remediating the underlying issues. – The organization identified and corrected issues and	High

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
		delays related to improper identification of populations, utilization data extracts, measure report set selection.	
Quartz	The organization fully met all requirements. No recommendations were identified.	The organization fully met all requirements.	N/A
SHP	The organization fully met all requirements. No recommendations were identified.	The organization fully met all requirements.	N/A
UHC	The organization fully met all requirements. No recommendations were identified.	The organization fully met all requirements.	N/A

Conclusions

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

Record Review – Children with Medical Complexity

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

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

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

The CMC record review is an optional activity. MetaStar reviewed 85 records of CMC participants enrolled through three hospitals. The review focused on five categories:

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

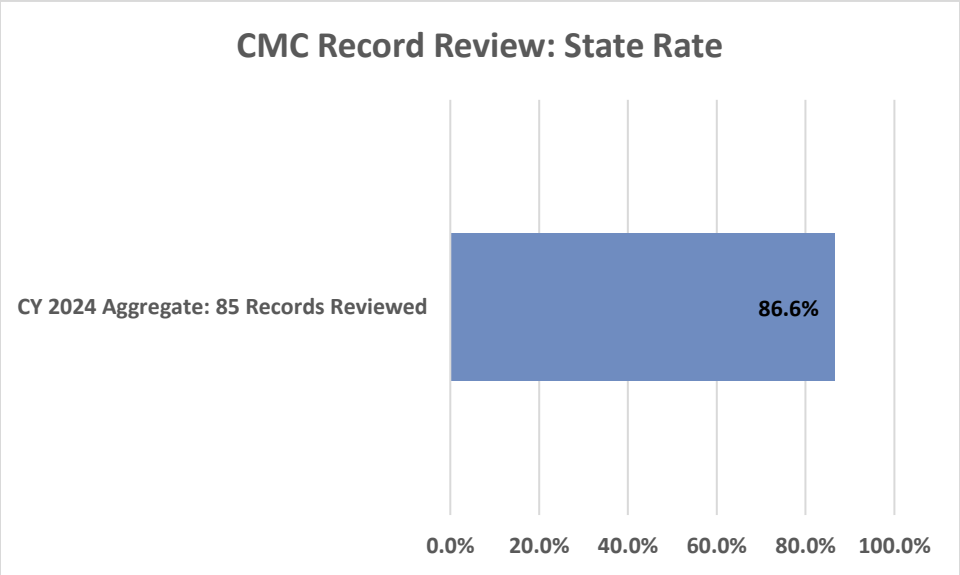
More information about the review methodology can be found in Appendix 2 and hospital comparative scores in Appendix 7.

Validation of care management practices was conducted for the following organizations:

Organization(s)	Program(s)
Children's Hospital of Wisconsin	CMC
Marshfield Children's Hospital	CMC
UW Health-American Family Children's Hospital	CMC

Overall Results

The bar graph below represents the overall percent of record review standards met by the hospitals in CY 2024 for all 17 review indicators. Following the CY 2023 review, revisions were made at the request of the Wisconsin Department of Health Services. Ratings from the previous review are not comparable; therefore, progress cannot be identified.



Results for each Record Review Focus Area

Each section below provides a brief explanation of a key category of record review, followed by a bar graph which represents the hospital's CY 2024 results for each of the review indicators comprising the record review category.

Eligibility and Enrollment

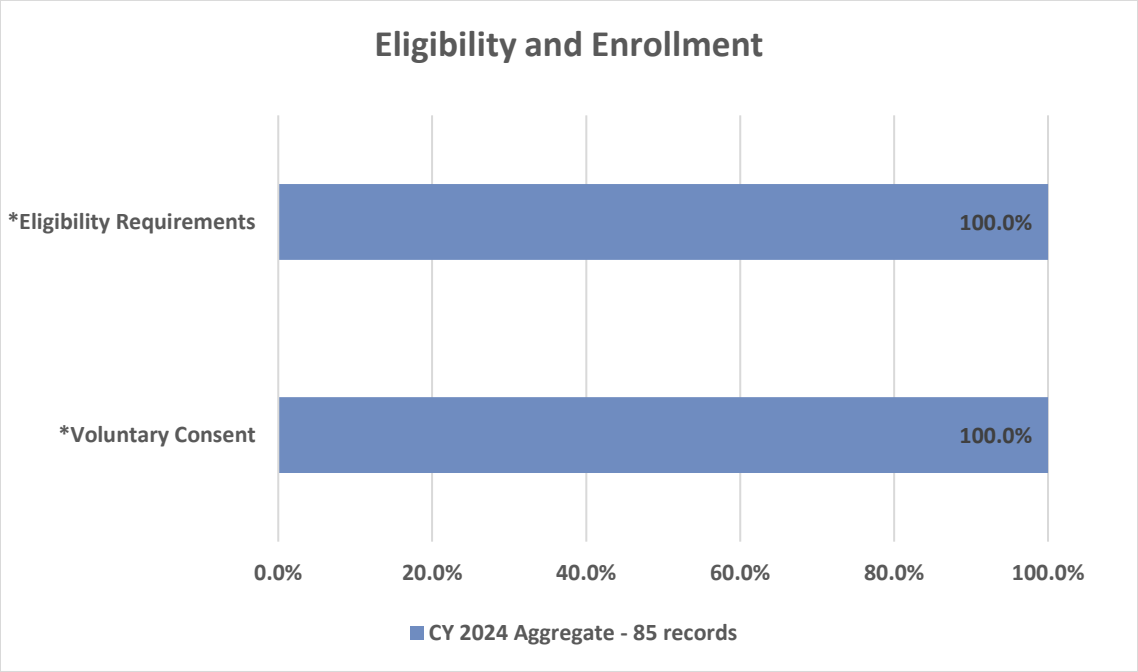
Members must be under age 26 with chronic health conditions involving three or more organ systems and requiring three or more medical or surgical specialists. Additionally, the member must have one or more hospital admissions (totaling five or more days), or at least ten visits to tertiary clinics within 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 Eligibility and Enrollment section only applies to members who newly enrolled into the program during the review period.

Of the 85 records reviewed, three members newly enrolled during the review period and were evaluated for eligibility and enrollment practices.

The indicator *Eligibility Requirements* ensures all members who receive services are eligible for the program. Program eligibility requirements were a strength for the hospitals.

The indicator *Voluntary Consent* ensures the member's legal guardian voluntarily consents to participate in the program. Obtaining voluntary consent for the CMC program was a strength for the hospitals.

The following graph demonstrates the hospitals' rate at which the standards were met for each indicator in CY 2024.



*Note: The review indicator *Eligibility Requirements* applied to three of 85 records in CY 2024. The review indicator *Voluntary Consent* applied to three of 85 records in CY 2024.

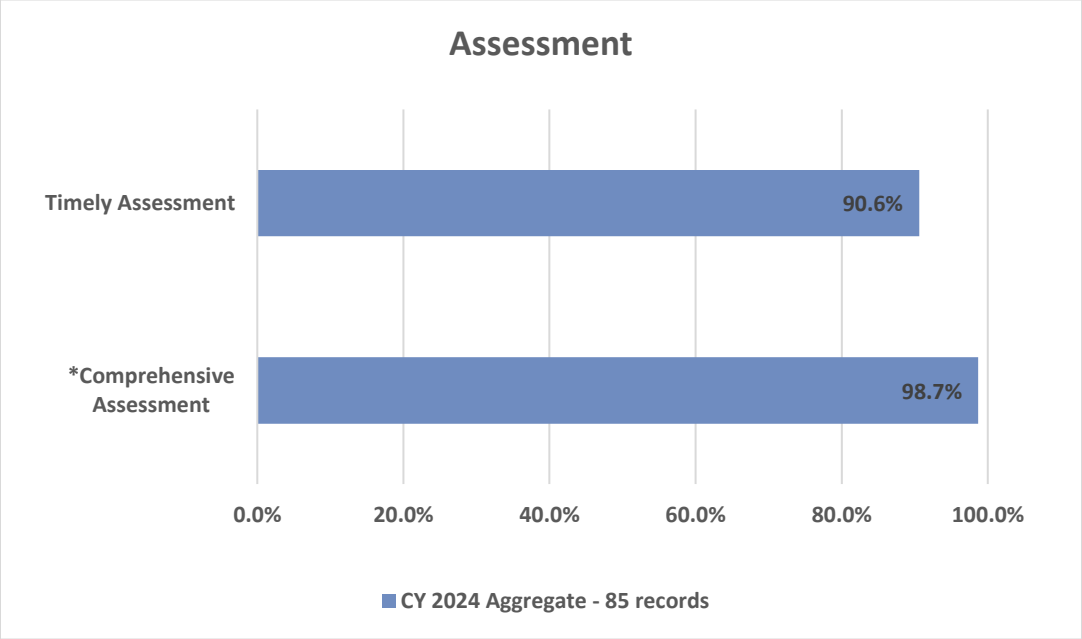
Assessment

Each member must have a comprehensive assessment that determines the member's need for medical, educational, social, or other services. Assessments must include an evaluation of the member's history, needs, strengths, and any other important member information. Assessments are completed prior to the development of the care plan.

The indicator *Timely Assessment* requires the member assessment be completed prior to the development of the care plan. The hospitals ensured most assessments were completed timely.

The indicator *Comprehensive Assessment* ensures the assessment include all required elements. The hospitals ensured most assessments were comprehensive.

The following graph demonstrates the hospitals' rate at which the standards were met for each indicator in CY 2024.



*Note: The review indicator *Comprehensive Assessment* applied to 77 of 85 records in CY 2024.

Care Plan

Each member must have a comprehensive care plan completed within 30 days of enrollment and at least once every six months, or after a change in member needs. A comprehensive care plan includes:

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

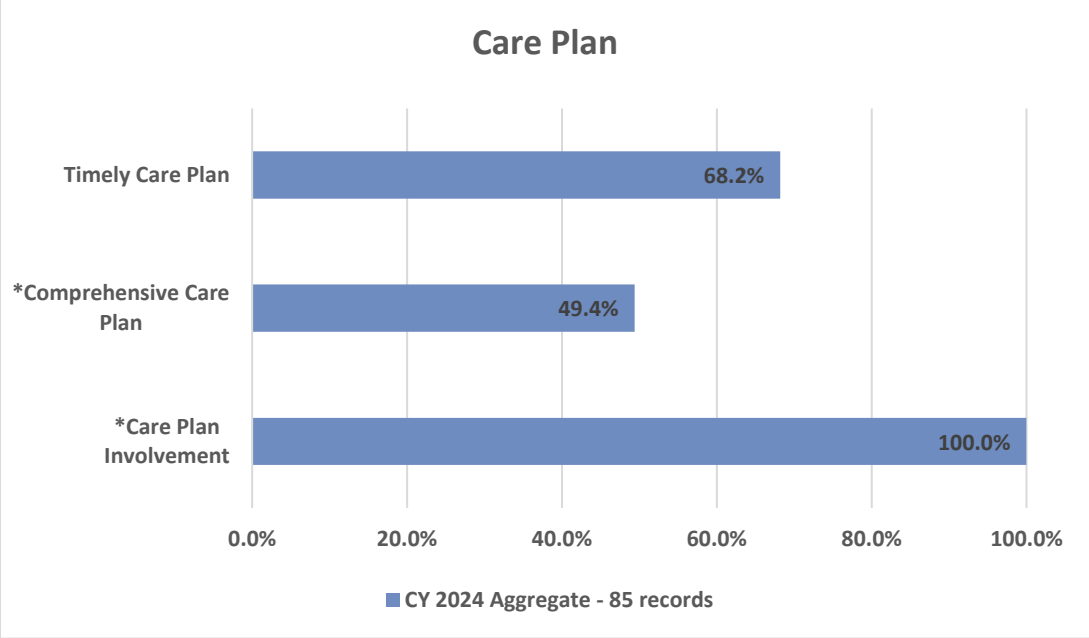
The initial care plan must also contain evidence that development occurred during a face-to-face meeting between the member, parent/legal guardian or caregiver, and physician or advanced practitioner.

The indicator *Timely Care Plan* requires the care plan to be completed within 30 days of enrollment, updated at least once every six months, and after a change in member needs. The results indicated a need for improvement. The most common reason care plans were not completed timely was care plans were not updated at least once every six months.

The indicator *Comprehensive Care Plan* ensures care plans include all required elements. The results indicated a need for improvement. The most common reason care plans were not comprehensive was goals were lacking actions and timeframes.

The indicator *Care Plan Involvement* requires the member, parent/legal guardian, and/or caregiver to be part of the care plan development. Additionally, a face-to-face visit from a physician or advance practice provider is required. Results demonstrated that the hospitals ensured that care plan development included the required team member involvement and a face-to-face visit from a physician or advance practice provider.

The following graph demonstrates the hospitals' rate at which the standards were met for each indicator in CY 2024.



*Note: The review indicator *Comprehensive Care Plan* applied to 77 of 85 records in CY 2024. The review indicator *Care Plan Involvement* applied to 77 of 85 records in CY 2024.

Ongoing Monitoring and Service Coordination

Care teams are required to conduct ongoing service coordination activities to ensure all identified needs are addressed. This includes a documented contact frequency plan between

the care team and member and/or family, coordination and follow-up of referrals, and arranging or attending acute care visits and specialty appointments when identified.

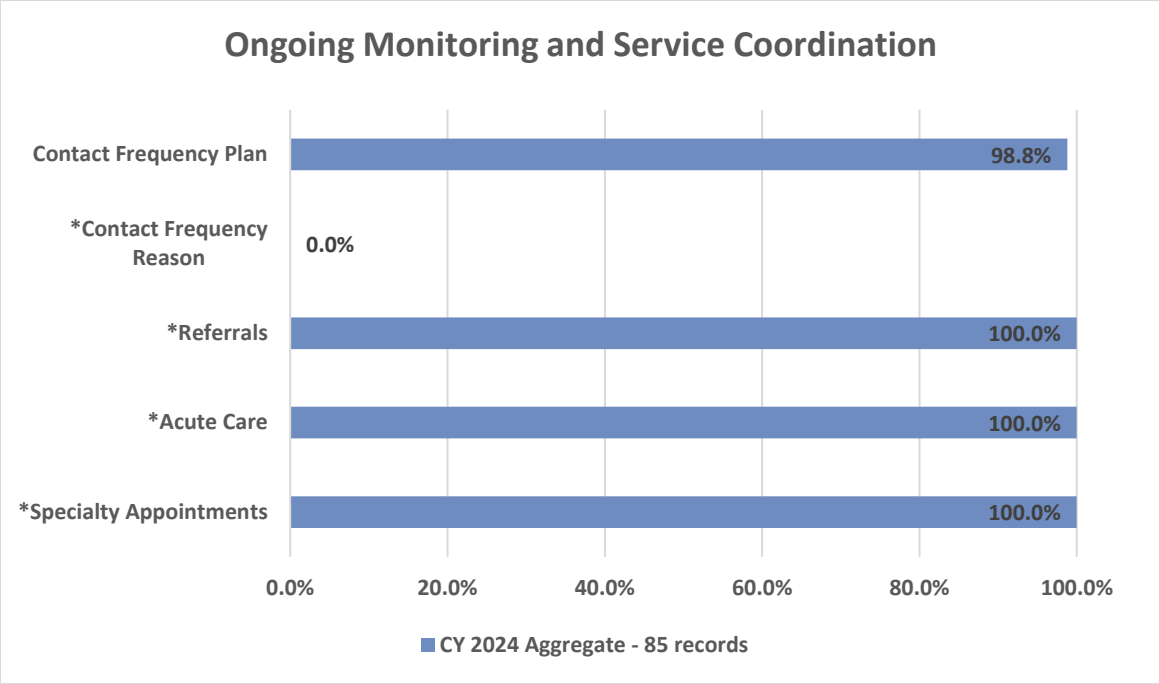
The indicator *Contact Frequency Plan* ensures the planned frequency of contact between the care team and member and family is documented in the record. This was an area of strength for the hospitals. The hospitals ensured the contact frequency plan was documented in the record.

The indicator *Contact Frequency Reason* requires that if the contact frequency plan is less than a monthly visit or contact, the reason is documented in the record. No records required a contact frequency plan that was less than a monthly visit or contact.

The indicator *Referrals* ensures referrals are coordinated, received follow-up, and were closed after the service was initiated. Of the records reviewed, 29 of 85 included referrals. The hospitals ensured all referrals were coordinated, received follow-up, and closed.

The indicator *Acute Care* requires the care team to arrange acute care visits when appropriate. Of the records reviewed, nine of 85 required the care team to arrange acute care visits. The hospitals ensured acute care visits were arranged when requested or appropriate.

The indicator *Specialty Appointments* requires the care team to attend specialty appointments when a need is identified. Of the records reviewed, two of 85 required the care team to attend specialty appointments. The hospitals ensured the care team attended specialty appointments when requested or identified as a need.



*Note: The review indicator *Contact Frequency Reason* applied to zero of 85 records in CY 2024. The review indicator *Referrals* applied to 29 of 85 records in CY 2024. The review indicator *Acute Care* applied to nine of 85 records in CY 2024. The review indicator *Specialty Appointments* applied to two of 85 records in CY 2024.

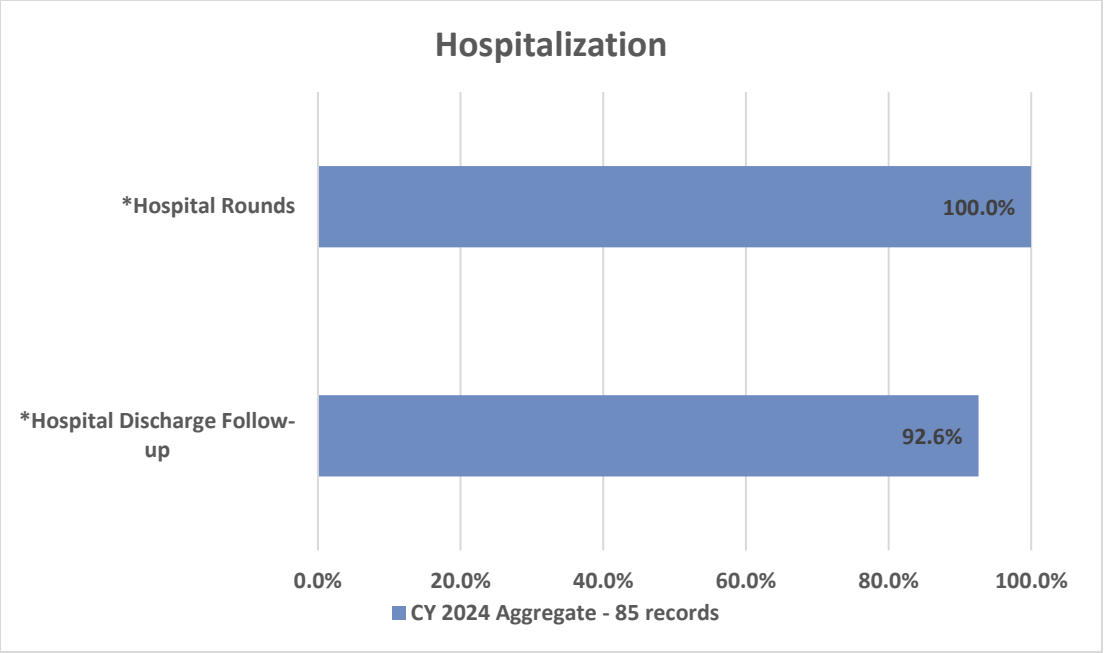
Hospitalization

If a member is hospitalized, the care team is required to provide ongoing service coordination to ensure member needs are addressed. During each hospitalization, the care team must make rounds during the member's inpatient stay, and follow up with the member within three business days of hospital discharge. Of the records reviewed, 27 of 85 members had a hospitalization during the review period.

The Indicator *Hospital Rounds* requires the care team to make rounds during the member's inpatient stay. Results demonstrated that this is an area of strength for the hospitals. The hospitals ensured the care team attended at least one round during members' hospital stays.

The Indicator *Hospital Discharge Follow-Up* requires the care team to follow up with the member within three business days after hospitalization discharge. Results demonstrated that this is an area of strength for the hospitals. The hospitals ensured the care team conducted timely follow-up with the member after discharge.

The following graph demonstrates the hospitals' rate at which the standards were met for each indicator in CY 2024.



*Note: The review indicator *Hospital Rounds* applied to 24 of 85 records in CY 2024. The review indicator *Hospital Discharge Follow-Up* applied to 27 of 85 records in CY 2024.

Service Refusal, Reduction, or Termination

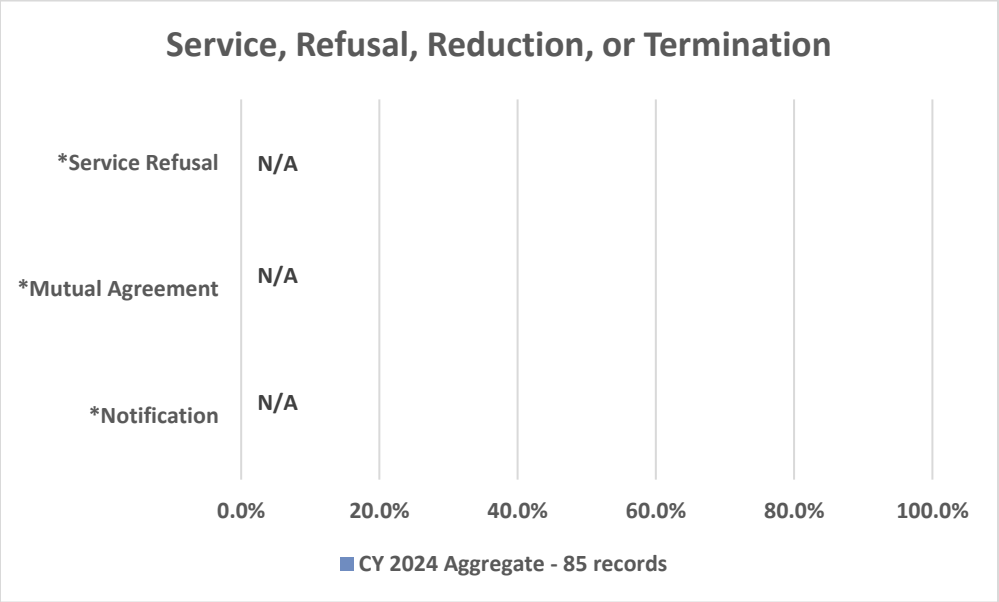
Service refusals must be documented in the record and reductions or terminations to services must be mutually agreed upon and the changes communicated to the legal decision maker in advance of implementing the change. When a member or family cannot be contacted, or refuses to adhere to the program's 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.

The Indicator *Service Refusal* ensures the record contains documentation of the member or family's refusal of case management services. No members refused case management services during the review period.

The Indicator *Mutual Agreement* ensures any service reduction or termination is mutually agreed upon by the member and family. No services were reduced or terminated during the review period.

The Indicator *Notification* requires the care team to notify the member and family of a service reduction or termination in advance. No services were reduced or terminated during the review period.

The following graph demonstrates the hospitals' rate at which the standards were met for each indicator in CY 2024.



*Note: The review indicator *Service Refusal* applied to zero of 85 records in CY 2024. The review indicator *Mutual Agreement* applied to zero of 85 records in CY 2024. The review indicator *Notification* applied to zero of 85 records in CY 2024.

Conclusions

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

Appendix 1 – List of Acronyms

AFCH	UW Health – American Family Children's Hospital
AIDS	Acquired Immunodeficiency Syndrome
ADR	Accreditation Desk Review
AMR	Asthma Medication Ratio
Anthem	Anthem Blue Cross and Blue Shield Health Plan
BC+	BadgerCare Plus
BCS-E	Breast Cancer Screening
BP	Blood Pressure
C4K	Care4Kids
CBP	Controlling Blood Pressure
CCS	Cervical Cancer Screening
CCF	Children Come First
CCHP	Chorus Community Health Plan, Inc.
CHIP	Children's Health Insurance Program
CFR	Code of Federal Regulations
CHW	Children's Hospital of Wisconsin
CIS	Childhood Immunization Status
CMC	Children with Medical Complexity
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DHP	Dean Health Plan, Inc.
DHS	Wisconsin Department of Health Services
ED	Emergency Department
EQR	External Quality Review
EQRO	External Quality Review Organization

FCMH	Foster Care Medical Home
FAR	Final Audit Report
FUH	Follow-Up After Hospitalization for Mental Illness
FUM	Follow-Up After Emergency Department Visit for Mental Illness
GHC-EC	Group Health Cooperative of Eau Claire
GHC-SCW	Group Health Cooperative of South Central Wisconsin
HBD	Hemoglobin A1C Control for Patients with Diabetes - HBA1 Control
HEDIS[6]	Healthcare Effectiveness Data and Information Set
Hep B	Hepatitis B Vaccine
HiB	Haemophilus Influenza type B Vaccine
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus Vaccine
*i*Care	Independent Care Health Plan
IMA	Immunizations for Adolescents
IS	Information System
ISCA	Information Systems Capabilities Assessment
LSC	Lead Screening in Children
MCHP	MercyCare Health Plans
MCO	Managed Care Organization
MCH	Marshfield Children's Hospital
MCW	My Choice Wisconsin, Inc.
MHS	MHS Health Wisconsin
MHWI	Molina Healthcare of Wisconsin
MY	Measurement Year
MCW	My Choice Wisconsin

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

MMR	Measels, Mumps, Rubella Vaccine
NAV	Validation of Network Adequacy
NCQA	National Committee for Quality Assurance
NHP	Network Health Plan
OB/GYN	Obstetrician Gynecologist
OHC	Out-of-Home Care
P4P	Pay For Performance
PMV	Performance Measure Validation
PCC	Primary Care Clinic
PCP	Primary Care Physician and Primary Care Provider
PCV	Pneumococcal Conjugate Vaccine
PDSA	Plan-Do-Study-Act
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PPC	Prenatal and Postpartum Care
QAPI	Quality Assessment and Performance Improvement
Quartz	Quartz Health Solutions, Inc.
SHP	Security Health Plan of Wisconsin, Inc.
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
SSI	Supplemental Security Income
UHC	United Healthcare of Wisconsin
VZV	Chicken Pox Vaccine
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 prepaid inpatient health plans (PIHPs) and managed care organizations (MCOs) to provide for external quality reviews (EQRs). To meet these obligations, states contract with a qualified external quality review organization (EQRO).

MetaStar - Wisconsin's External Quality Review Organization

The State of Wisconsin contracts with MetaStar, Inc. to conduct EQR activities and produce reports of the results. Based in Madison, Wisconsin, MetaStar has been a leader in health care quality improvement, independent quality review services, and medical information management for more than 50 years, and represents Wisconsin in the Superior Health Quality Alliance, under the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization Program.

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

MetaStar Review Team

The MetaStar EQR team is comprised of registered nurses, a physical therapist, counselors, licensed and/or certified social workers, and other degreed professionals with extensive education and experience working with the target groups served by the MCOs. The EQR team is supported by other members of MetaStar's External Quality Review Department as well as staff in other departments, including a data analyst with an advanced degree, a licensed Healthcare Effectiveness Data and Information Set (HEDIS®)[7] auditor, and information technologies staff.

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

MetaStar also contracts with a coding company with certified and/or credentialed coders. Review team experience includes professional practice and/or administrative experience in managed health and long-term care programs as well as in other settings, including community programs, schools, home health agencies, community-based residential settings, and the Wisconsin Department of Health Services (DHS). Some reviewers have worked in skilled nursing and acute care facilities and/or primary care settings. The EQR team also includes reviewers with quality assurance/quality improvement education and specialized training in evaluating performance improvement projects.

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

Review Methodologies

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

Validation of PIPs, a mandatory EQR activity, assesses if a MCO or PIHP used sound methodology in the design, implementation, analysis and reporting of its PIPs. The MetaStar team evaluated the organization's PIPs according to the methodology and significant improvement 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

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 ratings reflect the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data

collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement. Compliance with PIP requirements is expressed through validation ratings for the project's methodology and evidence of significant improvement. The validation ratings identified in the tables below reflect the EQRO's confidence in the PIP's methods and findings.

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

Significant Improvement Rating	
Validation Results	**Confidence Level**
High Confidence	90.0% - 100.0%
Moderate Confidence	80.0% - 89.9%
Low Confidence	70.0% - 79.9%
No Confidence	<70.0%

The methodology rating is based on the percentage of applicable scoring elements met for each standard. The 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.*

The significant improvement rating is determined through the use of a statistical test using the project's baseline and repeat measurement for each aim statement. If a project has multiple aim statements, the lowest confidence rating achieved is applied.

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. The MCO quality indicators for Calendar Year (CY) 2023, reported in CY 2024, are set forth in the annual *Wisconsin Department of Health Services (DHS) Division of Medicaid Services (DMS) HMO Quality Guide Measurement Year (MY2023)* for the Supplemental Security Income (SSI) and BadgerCare Plus (BC+) programs, and in the *Wisconsin Department of Health Services Division of Medicaid Services Foster Care Medical Home Quality Guide Measurement Year 2023* for the Foster Care Medical Home (FCMH) program. DHS has identified 10 performance measures for the BC+ program, seven for the SSI program, and eight for the FCMH program in CY 2023. The measures focus on access to care, preventative services, maternal health, chronic disease management, and behavior health outcomes.

According to 42 CFR §438.360, states have the option to utilize results from a private accreditation review to avoid duplication if the requirements are comparable to standards identified in the EQR protocols and 42 CFR §438.358. The performance measures identified by DHS are NCQA HEDIS® measures, which are standardized performance measures developed by NCQA and used to objectively measure, report and compare quality across health plans, and are validated by a certified NCQA HEDIS® auditor. MetaStar did not validate the measures but performed an analysis of the reported results.

MetaStar compared the State's performance on national HEDIS® measures with national benchmarks published annually by NCQA in the *Quality Compass®*[8] report with the permission of NCQA. These benchmarks represent performance of NCQA-accredited Medicaid MCO plans

[8] Quality Compass® is a registered trademark of NCQA.

and Medicaid MCO plans that are either required to report HEDIS® measures by the state agency responsible for monitoring managed Medicaid performance or opt to publicly report their HEDIS® rates. The HEDIS® measures reported to NCQA vary by plan. These national benchmarks reflect the average of the plans that reported the benchmark and are not a true national average of all managed Medicaid plans. Also, note these plans represent states with and without Medicaid expansion coverage.

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 National Committee for Quality Assurance (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 Desk Review affirms the MCO's accreditation status and evaluates compliance with the areas of the Compliance with Standards review not addressed by NCQA accreditation.

During CY 2021 MetaStar completed an *Accreditation Crosswalk* (crosswalk) as part of *DHS's Accreditation Deeming Plan* in the *Managed Care Quality Strategy*. The *Accreditation Deeming Plan* deems that a full Compliance with Standards review is duplicative for organizations with full NCQA Accreditation. The crosswalk compares the CFR Managed Care requirements to the NCQA accreditation standards, the DHS-MCO contract and annual DHS Certification Application to identify gaps in assuring full compliance with the regulations. The 2021 Medicaid Managed Care Quality Strategy is located at: 2021 Medicaid Managed Care Quality Strategy (wisconsin.gov.).

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

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

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

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

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

Focus Area	Related Sub-Categories in Review Standards
	• 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 NCQA and organizations accredited by an accrediting body not accepted by DHS.

MCO	Last Compliance Review	Next Compliance Review
GHC-EC	2022	GHC-EC obtained NCQA accreditation in 2023 and will participate in the ADR activity in 2025.
WM	2021	WM ceased program operations in 2024.

CMS External Quality Review (EQR) Protocols, Protocol 4: Validation of Network Adequacy

Validation of Network Adequacy evaluates the strength of each organization's provider network. The EQRO team evaluated network adequacy according to 42 CFR §438.68 Network Adequacy Standards using the CMS guide, *EQR Protocols Protocol 4: Validation of Network Adequacy.*

Prior to conducting review activities, the EQRO worked with DHS to identify its expectations for MCOs, including quantitative network adequacy standards

The review assesses the strengths, progress, and recommendations of the MCO related to the ability of its provider network to meet the standards identified by DHS to ensure the adequacy of providers to meet the needs of the members.

In January 2024, MetaStar used the information systems capabilities assessment (ISCA) scoring tool to collect information about the effect of the MCO's information management practices on encounter data submitted to DHS. Reviewers assessed information provided in the ISCA scoring tool, which was completed by the MCO and submitted to MetaStar. Some sections of the tool may have been completed by contracted vendors, if directed by the MCO. Reviewers also obtained and evaluated additional supplemental documentation specific to the MCO's IS and organizational operations used to collect, process, and report claims and encounter data.

For network adequacy validation, Myers and Stauffer reviewed the ISCA for the health plan and found no findings. In addition to ISCA, additional member and provider data was requested from the health plan in order to perform the network adequacy validation activities.

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

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

MetaStar randomly selected a sample of member records. The random sample included a mix of participants who enrolled during the last year, participants who had been enrolled for more than 90 consecutive days, and participants who had left the program since the sample was drawn.

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

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

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

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

- Screening;
- Care Planning;
- Care Coordination;
- Care Plan Review and Update;

- Transition Planning; and
- Wisconsin Interdisciplinary Care Team.

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

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

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

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

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

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

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

CMS External Quality Review (EQR) Protocols, 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 and DHS confirms each MCO receives an annual HEDIS® audit. MetaStar requests copies of each MCO's *HEDIS Compliance Audits*™[9]. Each organization's annual HEDIS® audit, as well as the plan's ability to report HEDIS® measures encompass the ISCA requirements. For organizations not evaluated by a NCQA certified HEDIS® Licensed Organization (LO), MetaStar conducts a full ISCA review.

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

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

Interview sessions were then held onsite or by video conference to collect additional information necessary to assess the MCO's compliance with federal and state standards. Participants in the interview sessions included MCO administrators, supervisors and other staff responsible for the organization's information systems.

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

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

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

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

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

Compliant:

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

Not Compliant:

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

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

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

Section 1: Background Information

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

Section 2: Information Systems: Data Processing & Personnel

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

Section 3: Staffing

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

Data Acquisition - Claims and Encounter Data Collection

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

Section 4: Security

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

Section 5: Data Acquisition Capabilities

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

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

MetaStar randomly selected a sample of member records. The random sample included a mix of members who enrolled during the last year, members who had been enrolled for more than 60 consecutive days, and members who had left the program since the sample was drawn.

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

- Eligibility and Enrollment
- Assessment
- Care Plan
- Ongoing Monitoring and Service Coordination
- Hospitalization

- Service Refusal, Reduction, or Termination

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

Appendix 3 – Validation of Performance Improvement Projects: CY 2024 MCO Comparative Scores

Section	Description	BC+ and SSI Managed Care Programs									
		Anthem	CCHP	Dean	GHC-EC	GHC-SCW	*i*Care	MCHP	MHS	MHWI	MCW
1	*PIP Topic*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2	*PIP Aim Statement*	91.7%	66.7%	100.0%	100.0%	100.0%	100.0%	83.3%	91.7%	58.3%	100.0%
3	*PIP Population*	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	75.0%	100.0%	100.0%	100.0%
4	*Sampling Method*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	*PIP Variables and Performance Measures*	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	91.7%	100.0%	100.0%	100.0%
6	*Data Collection Procedures*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
7	*Data Analysis and Interpretation of PIP Results*	92.9%	100.0%	100.0%	86.7%	87.5%	87.5%	50.0%	93.3%	87.5%	100.0%
8	*Improvement Strategies*	83.3%	91.7%	83.3%	91.7%	83.3%	91.7%	91.7%	100.0%	91.7%	100.0%
9	*Significant and Sustained Improvement*	100.0%	83.3%	90.0%	75.0%	85.7%	57.1%	66.7%	88.9%	40.0%	85.7%

Section	Description	BC+ and SSI Managed Care Programs			
		NHP	Quartz	SHP	UHC
1	*PIP Topic*	100.0%	100.0%	90.0%	100.0%
2	*PIP Aim Statement*	91.7%	75.0%	66.7%	100.0%
3	*PIP Population*	100.0%	75.0%	100.0%	100.0%
4	*Sampling Method*	N/A	N/A	N/A	N/A
5	*PIP Variables and Performance Measures*	100.0%	86.7%	100.0%	100.0%
6	*Data Collection Procedures*	100.0%	90.9%	92.0%	100.0%
7	*Data Analysis and Interpretation of PIP Results*	92.9%	73.3%	100.0%	100.0%
8	*Improvement Strategies*	100.0%	91.7%	75.0%	100.0%
9	*Significant and Sustained Improvement*	88.9%	16.7%	40.0%	75.0%

Section	Description	PIHP Managed Care Programs		
		C4K	CCF	WM
1	*PIP Topic*	100.0%	100.0%	100.0%
2	*PIP Aim Statement*	100.0%	100.0%	75.0%
3	*PIP Population*	100.0%	100.0%	100.0%
4	*Sampling Method*	N/A	N/A	N/A
5	*PIP Variables and Performance Measures*	100.0%	83.3%	80.0%
6	*Data Collection Procedures*	100.0%	85.7%	100.0%
7	*Data Analysis and Interpretation of PIP Results*	62.5%	60.0%	80.0%
8	*Improvement Strategies*	41.7%	60.0%	100.0%

Section	Description	PIHP Managed Care Programs		
		C4K	CCF	WM
9	*Significant and Sustained Improvement*	50.0%	75.0%	25.0%

Appendix 4 – Validation of Performance Measures: CY 2024 MCO Rates

Measure	BC+ Managed Care Rates													
	Anthem	CCHP	DHP	GHC-EC	GHC-SCW	iCare	MCHP	MHS	MHWI	MCW	NHP	Quartz	SHP	UHC
Children's Health – Primary Care Access and Preventative Care														
CIS	61.0%	61.1%	66.7%	58.2%	50.0%	64.5%	59.0%	60.6%	55.0%	59.6%	56.7%	58.1%	69.3%	65.2%
IMA	33.4%	38.8%	41.6%	38.4%	47.9%	29.4%	38.9%	31.4%	36.5%	28.6%	32.6%	38.4%	33.3%	35.0%
LSC	67.6%	73.6%	67.4%	62.3%	60.6%	72.0%	50.0%	65.6%	69.9%	68.9%	65.6%	45.6%	69.8%	70.1%
WCV	51.1%	52.4%	51.9%	46.4%	42.4%	42.0%	46.3%	46.5%	51.8%	47.4%	48.7%	47.1%	51.8%	50.3%
Maternal Health														
PPC-Prenatal Care	86.1%	84.7%	93.8%	92.2%	82.8%	82.2%	92.1%	88.6%	90.7%	72.2%	89.8%	82.8%	86.9%	90.8%
PPC – Postpartum Care	81.3%	85.9%	88.1%	87.8%	80.2%	74.2%	83.8%	79.3%	82.2%	71.9%	83.7%	82.8%	81.5%	80.8%
Disease Management – Chronic Conditions														
AMR	62.6%	70.9%	60.2%	76.0%	62.8%	63.8%	54.4%	70.4%	70.4%	64.4%	68.3%	66.5%	72.8%	61.6%
HBD	53.3%	57.7%	53.4%	66.4%	57.3%	53.8%	51.3%	58.2%	58.6%	36.3%	55.0%	57.2%	59.8%	57.4%
CBP	5.1%	5.2%	23.7%	17.6%	64.0%	21.9%	46.2%	15.7%	11.0%	33.2%	17.6%	24.4%	9.6%	3.4%
FUH	63.5%	62.5%	63.0%	66.4%	67.3%	65.7%	61.9%	69.3%	65.7%	60.1%	70.2%	59.0%	55.4%	61.3%

Measure	SSI Managed Care Rates									
	Anthem	GHC-EC	*i*Care	MHS	MHWI	MCW	NHP	Quartz	SHP	UHC
Chronic Conditions										
AMR	63.3%	73.0%	66.5%	75.0%	64.4%	63.4%	63.2%	N/A*	N/A*	57.1%
HBD	58.6%	63.3%	56.7%	59.1%	61.5%	63.0%	61.2%	N/A*	63.8%	61.8%
Behavioral Health										
FUH	60.3%	52.1%	78.3%	64.9%	65.3%	73.7%	64.3%	N/A*	N/A*	52.2%
FUM	44.8%	53.3%	52.9%	60.9%	60.2%	N/A*	68.9%	N/A*	N/A*	48.6%
SSD	84.2%	81.3%	80.3%	80.4%	78.4%	76.1%	78.3%	N/A*	N/A*	80.1%
Preventative Health										
BCS-E	52.3%	52.9%	50.6%	57.3%	49.2%	47.3%	54.7%	N/A*	71.0%	55.5%
CCS	15.3%	32.8%	12.1%	20.0%	39.4%	33.2%	52.3%	N/A*	48.6%	6.4%

*The rate had a denominator less than 30; therefore, was not reportable.

Appendix 5 – Compliance with Standards Review – Accreditation Desk Review: CY 2024 Quality Assessment and Performance Improvement & Grievance Systems Standards Comparative Scores

Standard	Citation	SSI & BC+ Managed Care Programs							
		Anthem	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
Q1	*General rules - 42 CFR §438.330(a)*	88.9%	88.9%	100.0%	88.9%	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%	100.0%	100.0%	100.0%	71.4%	100.0%	100.0%
Q3*	*Performance measurement - 42 CFR §438.330(c)*	N/A	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	N/A
Q5	*QAPI evaluations review - 42 CFR §438.330(e)(2)*	75.0%	50.0%	100.0%	50.0%	100.0%	50.0%	100.0%	100.0%

* Q3, and Q4 are evaluated through reviews that occur separate from the ADR.

Standard	Citation	SSI & BC+ Managed Care Programs							
G1	*Grievance systems - 42 CFR §438.228*	80.0%	100.0%	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%	85.7%	100.0%	100.0%	100.0%
G3	*Timely and adequate notice of adverse benefit determination - 42 CFR §438.404*	90.0%	90.0%	100.0%	100.0%	100.0%	70.0%	100.0%	100.0%

Standard	Citation	SSI & BC+ Managed Care Programs							
G4	*Handling of grievances and appeals - 42 CFR §438.406*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
G5	*Resolution and notification - 42 CFR §438.408*	84.6%	100.0%	92.3%	92.3%	92.3%	76.9%	100.0%	76.9%
G6	*Expedited resolution of appeals - 42 CFR §438.410*	66.7%	66.7%	100.0%	66.7%	100.0%	100.0%	100.0%	66.7%
G7	*Information about grievance and appeal system to providers and subcontractors - 42 CFR §438.414*	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
G8	*Record keeping requirements - 42 CFR §438.416*	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
G9	*Continuation of benefits while the local appeal and the state Fair Hearing are pending - 42 CFR §438.420*	75.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	75.0%
G10	*Effectuation of reversed appeal resolution - 42 CFR §438.424*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Standard	Citation	BC+ Managed Care Programs			
		CCHP	**DHP**	**GHC-SCW**	**MCHP**
Q1	*General rules - 42 CFR §438.330(a)*	100.0%	88.9%	100.0%	88.9%
Q2	*Basic elements of the quality assessment and performance improvement program - 42 CFR §438.330(b)*	100.0%	100.0%	100.0%	100.0%
Q3*	*Performance measurement - 42 CFR §438.330(c)*	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
Q5	*QAPI evaluations review - 42 CFR §438.330(e)(2)*	50.0%	75.0%	50.0%	50.0%

* Q3, and Q4 are evaluated through reviews that occur separate from the ADR.

Standard	Citation	BC+ Managed Care Programs			
G1	*Grievance systems - 42 CFR §438.228*	80.0%	100.0%	100.0%	100.0%
G2	*General requirements - 42 CFR §438.402*	100.0%	100.0%	100.0%	100.0%
G3	*Timely and adequate notice of adverse benefit determination - 42 CFR §438.404*	70.0%	70.0%	100.0%	70.0%
G4	*Handling of grievances and appeals - 42 CFR §438.406*	83.3%	100.0%	100.0%	100.0%
G5	*Resolution and notification - 42 CFR §438.408*	61.5%	76.9%	84.6%	92.3%
G6	*Expedited resolution of appeals - 42 CFR §438.410*	66.7%	66.7%	100.0%	100.0%
G7	*Information about grievance and appeal system to providers and subcontractors - 42 CFR §438.414*	0.0%	0.0%	0.0%	100.0%
G8	*Record keeping requirements - 42 CFR §438.416*	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%	50.0%	25.0%	100.0%
G10	*Effectuation of reversed appeal resolution - 42 CFR §438.424*	100.0%	50.0%	100.0%	100.0%

Appendix 6 – Conducting Focused Studies of Health Care Quality – SSI Care Management Review: CY 2024 MCO Comparative Scores

Indicator #	Indicator Description	SSI Managed Care Programs								
		Anthem	GHC-EC	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
1.1	Timely Screening	15.0%	56.0%	33.0%	28.0%	8.0%	25.0%	22.0%	18.0%	23.0%
1.2	Comprehensive Screen	100.0%	99.0%	77.0%	100.0%	88.0%	98.0%	61.0%	100.0%	96.0%
2.1	Timely Care Plan	41.0%	70.0%	44.0%	40.0%	17.0%	30.0%	28.0%	25.0%	34.0%
2.2	Comprehensive Care Plan	89.0%	81.0%	68.0%	100.0%	100.0%	100.0%	17.0%	93.0%	100.0%
2.3	Care Plan Distribution	75.0%	72.0%	76.0%	75.0%	68.0%	91.0%	50.0%	97.0%	75.0%
2.4	Care Plan Agreement	100.0%	98.0%	96.0%	97.0%	100.0%	100.0%	6.0%	97.0%	100.0%
3.1	Member Contact	20.0%	27.0%	54.0%	26.0%	25.0%	20.0%	20.0%	21.0%	30.0%
3.2	Timely Follow-Up	85.0%	72.0%	91.0%	62.0%	88.0%	50.0%	100.0%	50.0%	88.0%
4.1	Care Plan Review	11.0%	63.0%	31.0%	19.0%	3.0%	14.0%	19.0%	17.0%	17.0%
4.2	Change in Needs	50.0%	81.0%	60.0%	60.0%	62.0%	50.0%	100.0%	60.0%	85.0%
4.3	Member Re-Stratification	76.0%	100.0%	79.0%	70.0%	34.0%	48.0%	100.0%	8.0%	75.0%
5.1	Timely Transition Planning	31.0%	65.0%	50.0%	50.0%	27.0%	53.0%	0.0%	27.0%	50.0%

Indicator #	Indicator Description	SSI Managed Care Programs								
		Anthem	**GHC-EC**	***i*Care**	**MHS**	**MHWI**	**NHP**	**Quartz**	**SHP**	**UHC**
5.2	Transition Planning Follow-Up	31.0%	59.0%	50.0%	50.0%	20.0%	53.0%	0.0%	18.0%	43.0%
6.1	WICT Core Team	0.0%	94.0%	92.0%	100.0%	N/A	100.0%	N/A	N/A	N/A
6.2	Timely WICT Collaboration	0.0%	83.0%	92.0%	100.0%	N/A	100.0%	N/A	N/A	N/A
6.3	Timely WICT Member Contact	0.0%	80.0%	33.0%	50.0%	N/A	N/A	N/A	N/A	N/A

Appendix 7 – Record Review – Children with Medical Complexity: CY 2024 Hospital Comparative Scores

Indicator #	Indicator Description	Hospitals		
		AFCH	CHW	MCH
1.1	Eligibility Requirements	N/A	100.0%	100.0%
1.2	Voluntary Consent	N/A	100.0%	100.0%
2.1	Timely Assessment	93.3%	85.0%	100.0%
2.2	Comprehensive Assessment	96.4%	100.0%	100.0%
3.1	Timely Care Plan	73.3%	52.5%	100.0%
3.2	Comprehensive Care Plan	28.6%	47.1%	93.3%
3.3	Care Plan Involvement	100.0%	100.0%	100.0%
4.1	Contact Frequency Plan	96.7%	100.0%	100.0%
4.2	Contact Frequency Reason	N/A	N/A	N/A
4.3	Referrals	100.0%	100.0%	100.0%
4.4	Acute Care	100.0%	100.0%	N/A
4.5	Specialty Appointments	100.0%	N/A	N/A
5.1	Hospital Rounds	100.0%	100.0%	100.0%
5.2	Hospital Discharge Follow-Up	88.9%	93.8%	100.0%
6.1	Service Refusal	N/A	N/A	N/A
6.2	Mutual Agreement	N/A	N/A	N/A
6.3	Notification	N/A	N/A	N/A