MetaStar

External Quality Review

Fiscal Year 2022 – 2023

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Annual Technical Report

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

Final Report: November 16, 2023

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Executive Summary

External Quality Review Process

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

This report covers the external quality review fiscal year from July 1, 2022 to June 30, 2023 (FY 22-23). Mandatory review activities conducted during the year included assessment of compliance with federal standards, validation of performance measures, validation of performance improvement projects, and information systems capabilities assessments. MetaStar also conducted one optional activity, conducting focused studies of health care quality - care management review. Care management review assesses key areas of care management practice related to assurances found in the 1915(b) and 1915(c) Home and Community Based Services Waivers (HCBS), and also supports assessment of compliance with federal standards. All programs provide home and community-based services for long-term services and supports.

Scope of External Review Activities

Protocol 1: Validation of Performance Improvement Projects

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

Protocol 2: Validation of Performance Measures

Validation of performance measures is a mandatory review activity, required by 42 CFR 438.358, and is conducted according to federal protocol standards. The review assesses the accuracy of performance measures reported by the managed care organizations, and

determines the extent to which performance measures calculated by the managed care organizations follow state specifications and reporting requirements. The DHS contract with the managed care organizations specifies the quality indicators and standard measures organizations must calculate and report. MetaStar validated the completeness and accuracy of organizations' influenza and pneumococcal vaccination data for measurement year 2022. Technical definitions for each measure were provided by DHS.

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

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

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

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

Appendix V: Information Systems Capabilities Assessment

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

Analysis: Quality, Timeliness, Access

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

Additionally, different aspects of the State's *2021 Medicaid Managed Care Quality Strategy* supported by the review activities are identified.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 1: Validation of Performance Improvement Projects				
√	√	√	**STRENGTHS**	
			Review Findings	The State Quality Strategy
			The organizations conducted and reported detailed research regarding the topic selection and its importance to members.	Address health disparities. Foster independence. Focus on needs of the people being served through HCBS. Empower people to realize their full potential through access to an array of services and supports.
			All MCOs chose performance improvement project topics that aligned with State and Federal priorities focused on keeping members healthy, safe, and supported in the community when possible.	Address health disparities. Foster independence. Focus on needs of the people being served through HCBS. Empower people to realize their full potential through access to an array of services and supports.
			The organizations selected project variables and performance measures that were clear indicators of performance.	Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes. Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.
			Valid and reliable procedures were used to collect the projects' data and inform its measurements.	Build collaborative relationships with both internal and external stakeholders and partners.
			Appropriate, evidence-based interventions were selected and implemented that were likely to lead to the desired improvement.	Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes. Serve people through culturally competent practices and policies.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 1: Validation of Performance Improvement Projects				
			PROGRESS	
			Review Findings	The State Quality Strategy
			The organizations conducted analysis to determine reasons for less than optimal improvement.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Establish clear, concise, measurable, and answerable aim statements for projects.	Address health disparities. Foster independence. Focus on needs of the people being served through HCBS. Empower people to realize their full potential through access to an array of services and supports.
			Recognize and account for factors that may influence the comparability of initial and repeat measures in order to assess improvement in desired outcomes.	Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.
			Conduct tests of statistical significance between initial and repeat measures to determine if any observed improvement is the result of the intervention.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.
			Clearly identify project populations in relation to the aim statements.	Focus on needs of the people being served through HCBS.
			Compare project results across multiple entities or subgroup.	Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.
			Present project findings in a concise and easily understood manner.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 1: Validation of Performance Improvement Projects				
			Utilize the same methodology for initial and repeat measurement in order to allow comparability of results.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 2: Validation of Performance Measures Validation				
√	√	√	**STRENGTHS**	
			Review Findings	The State Quality Strategy
			Organizations continue to educate members on the benefits of the vaccinations, even if they decline to receive the vaccine.	Assess and support all dimensions of holistic health.
			PROGRESS	
			Review Findings	The State Quality Strategy
			No progress was identified in this review.	Not applicable.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Conduct a root cause analysis to identify the declining influenza and pneumococcal vaccination rates. Rates declined for a third year in a row and for all managed care organizations operating these programs. Continue to focus efforts on educating members on the benefits of receiving vaccinations, specifically influenza vaccinations, to ensure members stay as healthy as possible.	Assess and support all dimensions of holistic health. Focus on needs of the people being served through HCBS.

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

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review				
			Review Findings	The State Quality Strategy
			Organizations demonstrated a high level of compliance with managed care regulations and quality.	Ensure member health and safety by the acute care and long-term care programs. Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. Support individuals who use HCBS to actively participate in the design, implementation, and evaluation of the system at all levels.
			Robust provider networks that ensure timely access to services were evidenced throughout the organizations.	Ensure member care is delivered in a timely and effective manner.
			Efforts to promote cultural diversity were demonstrated through a variety of means by the organizations, such as trainings and community outreach.	Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes.
			Strong practices related to the coordination of member care, disenrollment procedures, and services authorizations were evidenced.	Ensure member care is delivered in a timely and effective manner. Support individuals who use HCBS to actively participate in the design, implementation, and evaluation of the system at all levels.
			All organizations demonstrated a high level of compliance with enrollee rights and protections.	Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes. Promote and protect the human and legal rights of individuals who use HCBS.
			PROGRESS	
			Review Findings	The State Quality Strategy

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review				
			Recommendations related to the monitoring of member restrictive measures were fully implemented.	Ensure member health and safety by the acute care and long-term care programs. Promote and protect the human and legal rights of individuals who use HCBS.
			Recommendations related to debarment verification were evidenced in most organizations.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Ensure organizations comply with written policies for the selection and retention of providers.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. Ensure member health and safety by the acute care and long-term care programs.
			Continue efforts to ensure requirements related to care management are fully implemented.	Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values. Support individuals who use HCBS to actively participate in the design, implementation, and evaluation of the system at all levels.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 9: Conducting Focused Studies of Health Care Quality				
√	√	√	**STRENGTHS**	
			Review Findings	The State Quality Strategy
			All programs demonstrated the ability to sufficiently support members, as evidenced by no members identified with unaddressed health and safety issues, and only one out of 1,895	Ensure member health and safety by the acute care and long-term care programs. Ensure member care is delivered in a timely and effective manner.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 9: Conducting Focused Studies of Health Care Quality				
			members identified for complex and challenging situations. Strong practices related to upholding member rights were evidenced in all programs. Appropriate handling of services authorizations and timely coordination of member services was a statewide strength. Conducting assessments timely and ensuring an annual review of the member's care plan was a statewide strength.	Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes. Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values. Promote and protect the human and legal rights of individuals who use HCBS.
			PROGRESS	
			Review Findings	The State Quality Strategy
			Ensuring member contact requirements were achieved improved on a statewide basis.	Ensure member health and safety by the acute care and long-term care programs. Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Focus efforts to increase the comprehensiveness and timeliness of member-centered plans in the Family Care and Family Care Partnership programs, specifically in Geographical Service Regions 8 and 11 for both programs.	Ensure member health and safety by the acute care and long-term care programs. Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values.
			Ensure care plans are shared with essential providers in the Family Care and Family Care Partnership programs, specifically in Geographical Service Regions 1, 2, 3, 4, 8, 10, 11, 12 and 14 of the Family Care Program; Geographical Service Regions 8,	Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 9: Conducting Focused Studies of Health Care Quality				
			10, and 11 of Family Care Partnership program.	
			Focus efforts on improving follow-up to ensure member supports and services are adequate in the Family Care, Family Care Partnership, and PACE programs specifically in Geographical Service Regions 1, 2, 4, 5, 10, 11, and 12 of the Family Care program; Geographical Service Regions 2, 8, and 12 of the Family Care Partnership program; and Geographical Service Region 11 of the PACE program.	Ensure member health and safety by the acute care and long-term care programs. Ensure member care is delivered in a timely and effective manner.
			Ensure staff are making the minimum member contacts as required by DHS for the Family Care Partnership program, specifically in Geographical Service Regions 8, 12, and 14.	Ensure member health and safety by the acute care and long-term care programs. Ensure member care is delivered in a timely and effective manner.
			Focus efforts to improve consistency between the *Long Term Functional Screen* and documentation in the member's record at the managed care organization for all programs specifically in Geographical Service Regions 2, 7, 8, 11 and 12 of the Family Care program; Geographical Service Regions 2, 5, 9, 12 and 14 of the Family Care Partnership program; and Geographical Service Region 6 and 11 of the PACE program.	Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes. Ensure member care is delivered in a timely and effective manner.
			Ensure members are rescreened when a change in condition occurs for all programs specifically in Geographical Service Regions 3, 4, 7, 9, 12, and 13 of the Family Care program; Geographical Service Regions 5, 10, 11, and 12 of the Family Care Partnership program;	Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes. Ensure member care is delivered in a timely and effective manner.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Protocol 9: Conducting Focused Studies of Health Care Quality				
			and Geographical Service Region 6 and 11 of the PACE program.	

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Appendix V: Information Systems Capabilities Assessments				
√	√	√	**STRENGTHS**	
			Review Findings	The State Quality Strategy
			Strong systems are maintained and updated by stable and experienced information system departments. Robust and ongoing training was in place to ensure all Medicaid data is processed accurately and within the expected timeframes. Security systems met or exceeded most industry standards, ensuring consistent system and data availability. Processes and systems for collecting and maintaining administrative data and enrollment information ensured accurate encounter data is provided to the state.	Ensure timely access to complete and accurate health data. Evaluate data systems to ensure they effectively support programs and strategies in collecting relevant and adequate clinical and other data from multiple sources. Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.
			PROGRESS	
			Review Findings	The State Quality Strategy
			Improved the ability to obtain segment breakdowns of paper versus electronic claims and continued to encourage providers to transition to electronic submission of claims.	Ensure timely access to complete and accurate health data.
			RECOMMENDATIONS	
			Review Findings	The State Quality Strategy
			Continue to monitor claims from a third-party vendor to ensure completeness of data in the encounter submission files.	Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.

Quality	Timeliness	Access	Strengths, Progress, and Recommendations and The State Quality Strategy	
Appendix V: Information Systems Capabilities Assessments				
			Explore the possibility of consolidating the number of systems the organization uses to manage claims processing, in order to improve efficiencies.	

Introduction and Overview

Acronyms and Abbreviations

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

Purpose of the Report

This is the annual technical report that the State of Wisconsin must provide to the Centers for Medicare & Medicaid Services (CMS) related to the operation of its Medicaid managed health and long-term care programs; Family Care (FC), Family Care Partnership (FCP), and Program of All-Inclusive Care for the Elderly (PACE). The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate pre-paid inpatient health plans and managed care organizations (MCOs) to provide for periodic external quality reviews. This report covers mandatory and optional external quality review (EQR) activities conducted by the external quality review organization (EQRO), MetaStar, Inc., for the fiscal year from July 1, 2022, to June 30, 2023 (FY 22-23). See Appendix 2 for more information about external quality review and a description of the methodologies used to conduct review activities.

Overview of Wisconsin's FC, FCP, and PACE Managed Care Organizations

The table below identifies the programs each MCO operates.

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

Effective January 1, 2023 the first phase of the Wisconsin Department of Health Services (DHS') reconfiguration plans for the geographic service regions (GSR) was implemented. GSR 1 and GSR 7 were combined into a single GSR (GSR 1) and GSR 7 was eliminated. At the same time, DHS certified MCW to expand into all counties in GSR 1. The MCO will provide FC services in this GSR.

Links to maps depicting the current FC and FCP/PACE GSRs and the MCOs operating in the various service regions throughout Wisconsin can be found at the following website:

https://www.dhs.wisconsin.gov/familycare/mcos/index.htm.

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

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

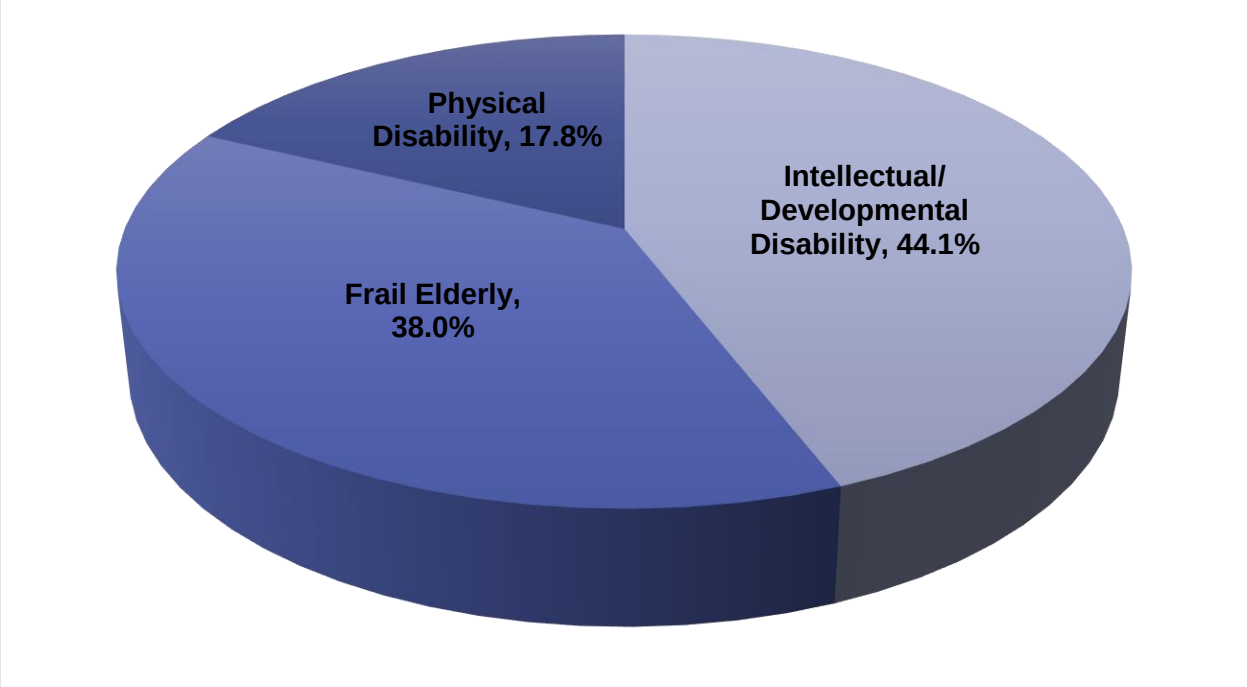
https://www.dhs.wisconsin.gov/familycare/fcp-overview.htm.

As of September 1, 2023, enrollment for all programs was approximately 57,703. This compares to last year's total enrollment of 56,756 as of August 1, 2022. Enrollment data is available at the following DHS website:

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

The following chart shows the percent of total enrollment by the primary target groups served by FC, FCP, and PACE programs; individuals who are frail elders, persons with intellectual/ developmental disabilities, and persons with physical disabilities.

Total Participants in All Programs by Target Group: September 1, 2023



Analysis: Quality, Timeliness, and Access

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

<table>
<tr><th colspan="3">Community Care, Inc.</th></tr>
<tr><th>Programs Operated</th><th>FY 22-23 Enrollment by Program</th><th>GSRs</th></tr>
<tr><td>FC, FCP, PACE</td><td>FC: 13,944 FCP: 759 PACE: 518</td><td>6, 8, 9, 10, 11, 12</td></tr>
<tr><th colspan="3">Findings</th></tr>
<tr><td colspan="2">Protocol 1: Validation of Performance Improvement Projects
Clinical PIP: Health Equity
Nonclinical PIP: Member Satisfaction</td><td>Strengths
– The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects.
– The organization established a clear, concise, measurable and answerable aim statement for one project.
– The organization clearly identified the PIP population in relation to the aim statement for both projects.
– The organization selected PIP variables and performance measures that were clear indicators of performance for both projects.
– The organization used valid and reliable procedures to collect the PIP data and inform its measurements for one project.
– The organization used appropriate techniques to analyze the PIP data and interpret the results for one project.
– The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects.
– The organization demonstrated statistically significant improvement that may be the result of its selected interventions for one project.

Progress
– The aim statements in both projects were concise.
– The analysis accounted for factors that may influence the comparability of initial and repeat measurements.
– The improvement strategies for both projects were culturally and linguistically appropriate.
– Improvement strategies were designed to account for barriers encountered during the project.
The baseline and repeat measurements were comparable in both projects.</td></tr>
</table>

Community Care, Inc.		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FC, FCP, PACE	FC: 13,944 FCP: 759 PACE: 518	6, 8, 9, 10, 11, 12
Findings		
	Recommendations – Specify a time period for each aim statement, including a start and end date to ensure the aim statements are answerable. – Include the frequency of data collection in the report, and ensure the collection plan links to the data analysis plan. – Assess the statistical significance of initial and repeat measurements for all aim statements. – Ensure project results are presented in a concise and easily understood manner. – Conduct statistical testing for each aim with observed improvement.	
Protocol 2: Validation of Performance Measures	**Strengths** – The PACE program demonstrated practices to ensure members receive pneumococcal vaccinations after the age of 65. **Progress** – The measurement year 2022 pneumococcal vaccination rates for the Family Care program reflected a statistically significant improvement from the prior measurement year. – The organization updated the pneumococcal clinical practice guideline to align with the *DHS Technical Definition.* **Recommendations** – Conduct a root cause analysis for the influenza vaccination rates that declined from the prior review. The vaccination rates declined for a third consecutive year in the Family Care program. Identifying the root cause or causes will allow the organization to focus improvement efforts. – Continue efforts to increase influenza vaccination rates for Family Care, Family Care Partnership, and PACE programs. – Continue efforts to increase pneumococcal vaccination rates for the Family Care and Family Care Partnership programs. – Update policies, procedures, and staff and member educational materials to reflect co-administration of the influenza and Coronavirus Disease 2019 (COVID-19) vaccines, or deferral of the influenza vaccine for those who have moderate or severe COVID-19, as noted in the *DHS Technical Definition.*	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	**Strengths** – The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected. – The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. – The organization demonstrated the ability to ensure coordination and continuity of member care. – Advance Care Planning Specialists serve as a resource for staff in providing education and review of advance directives to ensure they meet Wisconsin requirements. When requested, the Specialists provide	

Community Care, Inc.		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FC, FCP, PACE	FC: 13,944 FCP: 759 PACE: 518	6, 8, 9, 10, 11, 12
Findings		
	education and assistance to members in the completion of advance directives. **Progress** – The organization updated internal procedures with additional debarment guidance, specifically related to debarment checks of individual names and entity names. – The organization updated the Letter of Agreement template to include the necessary requirements and responsibilities of the organization and provider. **Recommendations** – Update internal procedures to provide clarity when a contracted provider is not included in the external provider directory and include how that information is available to the organization's Interdisciplinary Team staff through the internal provider database. – Update internal policies and procedures with additional guidance to include the credentialing process for when there is a need for continuation of services, specifically related to new providers. – Develop and implement a consent form for members to receive electronic materials for all programs that includes options for all member materials.	
Protocol 9: Conducting Focused Studies of Health Care Quality *Sample Sizes* *FC: 267* *FCP: 200* *PACE: 179*	**Strengths** – Comprehensive assessment practices were strengths for the PACE program. – PACE had strong practices in place for member-centered planning. – The organization demonstrated strengths in assuring health and safety needs of members were satisfied in all programs. **Progress** – The Family Care Partnership program improved practices related to member contact requirements for interdisciplinary team staff. **Recommendations** – Improve timeliness of follow-up for member needs and services in all programs, especially for medical appointments. – Continue to focus efforts on improving comprehensiveness of assessments and member-centered plans in the Family Care and Family Care Partnership programs. – Ensure signatures from members or legal decision makers are obtained on member-centered plans, at least every six months for the Family Care and Family Care Partnership programs. – Improve practices for updating the member-centered plan when a member has a change in condition in the Family Care Partnership program. – Ensure requirements related to essential providers are satisfied in the Family Care and Family Care Partnership programs.	

Community Care, Inc.		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FC, FCP, PACE	FC: 13,944 FCP: 759 PACE: 518	6, 8, 9, 10, 11, 12
Findings		
	– Focus efforts to improve consistency between the managed care organization's documentation and the *Long Term Care Functional Screen* in all programs. – Ensure rescreening with the *Long Term Care Functional Screen* is completed when members have a change in condition for all programs.	
Appendix V: Information Systems Capabilities Assessments	Not applicable. Reviewed in FY 20-21.	

Inclusa, Inc.		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FC	FC: 17,169	1, 2, 3, 4, 5, 6, 9,10,13,14
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Clinical PIP: Care Transitions* • *Nonclinical PIP: Health Equity*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for one project. – The organization clearly identified the PIP population in relation to the aim statement for one project. – The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization demonstrated statistically significant improvement that may be the result of its selected interventions for both projects. **Progress** – The organization included variables that answered the aim statement. – The organization described how the project monitored, compared, and tracked variables over time. – The organization clearly defined the data sources for both projects. – The organization conducted statistical analysis of the difference between baseline and repeat measures to confirm the change was statistically significant. – The report evidenced that the improvement between baseline and the repeat measure for both projects was due to the interventions. **Recommendations** – Identify time periods with start and end dates for all aim statements in future reports to ensure the aim statements are measurable. – Clearly define all inclusion and exclusion criteria for the study population in future reports. – Describe the process utilized to confirm all eligible members are included in the study population. – Identify all data collection methods in future reports. – Specify the frequency of data collection.	

Inclusa, Inc.		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FC	FC: 17,169	1, 2, 3, 4, 5, 6, 9,10,13,14
Findings		
	– Ensure the analysis plan corresponds to the data collection plan. – Ensure data analysis plans are established for all project aims in future reports. – Compare project results with other entities and/or subgroups. – Include strategies to address root causes and barriers. – Conduct Plan-Do-Study-Act cycles throughout the project. – Include cultural and linguistic considerations of improvement strategies in future reports. – Include methods to address factors that may influence the outcome of the project in future reports.	
Protocol 2: Validation of Performance Measures	**Strengths** – No strengths were identified for this review. **Progress** – No progress was identified for this review. **Recommendations** – Conduct a root cause analysis for the influenza and pneumococcal vaccination rates that declined from the prior review. The influenza vaccination rate declined for a third consecutive year. Identifying the root cause or causes will allow the organization to focus improvement efforts. – Continue efforts to increase influenza vaccination rates. – Continue efforts to increase pneumococcal vaccination rates.	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	**Strengths** – The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected. – The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. – The organization demonstrated the ability to ensure coordination and continuity of member care. – The organization had a handbook for interdisciplinary staff as a reference for care management practices. – The organization demonstrated a strong internal file review process aimed to improve care management practices. **Progress** – The organization implemented systems to ensure that a self-directed supports guidebook is provided to all members at enrollment. – The organization updated written guidance to add clarity for when a contracted provider is not included in the provider directory. – The organization updated written guidance to include giving the affected providers written notice of the reason for decision if the MCO declines to include the provider in the network.	

Inclusa, Inc.		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FC	FC: 17,169	1, 2, 3, 4, 5, 6, 9,10,13,14
Findings		
	Recommendations – Update written guidance and educate all providers on the specific reasons providers may advocate for members. – Review and update organizational processes to ensure that restrictive measure applications are submitted timely to the Wisconsin Department of Health Services and that renewals are approved prior to expiration. – Review and align recredentialing processes and practices to ensure consistency within the organization and with providers. – Update internal procedures with additional debarment guidance, specifically related to new providers and providers using legal names and business names, and have a plan in place for debarment monitoring if potential barriers arise, such as staff changes. – Review and update policies and procedures pertaining to caregiver background check monitoring to ensure there is consistency within the organization and with providers. Ensure representative samples sizes when conducting *Best Practice Reviews*.	
Protocol 9: Conducting Focused Studies of Health Care Quality *Sample Size* *FC: 267*	**Strengths** - The organization demonstrated strengths in assuring health and safety needs of members were satisfied. **Progress** – No progress was made on the recommendations from the prior review. **Recommendations** – Continue efforts to improve the comprehensiveness of assessments through ensuring assessment of member educational experiences and preferences. – Continue efforts to improve the comprehensiveness of member-centered plans by including services and supports for assessed needs. – Focus efforts on distributing member-centered plans to essential providers, especially supportive home care providers. – Continue efforts to ensure timely follow-up for effectiveness of services, specifically related to medical appointments and durable medical equipment. – Focus efforts on improving the consistency between the *Long Term Care Functional Screen* functional ratings and organization documentation of member abilities to ensure member needs are adequately supported. – Ensure members are rescreened with the *Long Term Care Functional Screen* following a change in condition.	
Appendix V: Information Systems Capabilities Assessment	Not applicable. Reviewed in FY 20-21.	

*i*Care		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FCP	FCP: 1,553	3, 8, 11,12
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Clinical PIP: Falls Risk* • *Nonclinical PIP: Behavioral Support*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for one project. – The organization clearly identified the PIP population in relation to the aim statement for one project. – The organization selected PIP variables and performance measures that were clear indicators of performance for one project. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. – The organization demonstrated statistically significant improvement that may be the result of its selected interventions for one project. **Progress** – The aim statements remained consistent for the duration of the projects. – The aim statements included goals that exceeded the baseline measurements. – The report clearly described all details of the data analysis plan. – The report included statistical analysis between the baseline and repeat measure. **Recommendations** – Include a specific time period for the PIP in the aim statement. – Ensure the aim statement is answerable by including all required criteria in the aim statement. – Ensure all inclusion and exclusion criteria for the study population are included. – Include the strategy to ensure inter-rater reliability for the performance measure. – Account for factors that may influence the comparability of initial and repeat measures. – Include a comparison of results across multiple entities, such as member subgroups, providers, or other organizations. – Complete accurate calculations of results to ensure results are easily understood. – Explain how the selected improvement strategy will likely lead to the desired improvement. – Ensure the same methodology is used to calculate the baseline and repeat measures. – Demonstrate quantitative evidence of improvement with comparable baseline and repeat measures. – Explain how the improvement was likely a result of the selected intervention.

*i*Care		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FCP	FCP: 1,553	3, 8, 11,12
Findings		
	– Complete statistical testing of comparable measures.	
Protocol 2: Validation of Performance Measures	**Strengths** – No strengths were identified for this review. **Progress** – No progress was identified for this review. **Recommendations** – Conduct a root cause analysis for the influenza and pneumococcal vaccination rates that declined from the prior review. Both vaccination rates declined for a third consecutive year. Identifying the root cause or causes will allow the organization to focus improvement efforts. – Continue efforts to increase influenza vaccination rates. – Continue efforts to increase pneumococcal vaccination rates. – Amend policies and procedures to incorporate the most current *DHS Technical Definition* for each quality measure. – Update staff and member educational materials to reflect co-administration of the influenza and COVID-19 vaccines, or deferrals of the influenza vaccine for those who have moderate or severe COVID-19, as noted in the *DHS Technical Definition.* – Conduct a root cause analysis to determine the reason for members age 65 and older remaining in the Physical Disability target group for the pneumococcal vaccination after DHS implemented the target group automation for the *Long Term Care Functional Screen* in early 2017.	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	**Strengths** – The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected. – The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. **Progress** – The prior quality compliance review had very few recommendations for the organization to address; as such, progress was not indicated in this year's quality compliance review. **Recommendations** – No recommendations identified in this review.	
Protocol 9: Conducting Focused Studies of Health Care Quality *Sample Size* *FCP: 228*	**Strengths** – The organization demonstrated the ability to ensure coordination and continuity of member care. **Progress** – Progress was identified in the care management review related the handling of service authorizations.	

*i*Care		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FCP	FCP: 1,553	3, 8, 11,12
Findings		
	Recommendations – Continue efforts to ensure timely follow-up for effectiveness of services. – Focus efforts on improving the comprehensiveness and timeliness of member-centered plans. – Implement practices to obtain signatures from all essential providers on an annual basis. – Ensure timely follow-up for member's needs and services, specifically related to medical appointments. – Evaluate practices related to contact requirements to ensure interdisciplinary teams are contacting members at the required frequency. – Focus efforts to increase the consistency between member's *Long Term Care Functional Screen* and managed care organization documentation, specifically related to durable medical equipment for mobility and toileting. – Ensure a rescreen is conducted when a member has a change in condition.	
Appendix V: Information Systems Capabilities Assessment	**Strengths** – The organization has a strong system that is maintained and updated by a stable and experienced information system department. – The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes. – The organization's security systems met or exceeded most industry standards, ensuring consistent system and data availability. – The organization's processes and system for collecting and maintaining administrative data and enrollment information ensured accurate encounter data is provided to the state. **Progress** – The organization improved its ability to obtain segment breakdowns of paper versus electronic claims and continues to encourage providers to transition to electronic submission of claims. **Recommendations** – Continue to monitor claims from the third-party vision vendor to ensure completeness of data in the encounter submission files.	

Lakeland Care, Inc.		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FC	FC: 7,294	4, 9, 10,13
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Clinical PIP: Comprehensive Diabetes Care: Nutrition* • *Nonclinical PIP: Health Equity*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization established a clear, concise, measurable and answerable aim statement for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects.	

Lakeland Care, Inc.		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FC	FC: 7,294	4, 9, 10,13
Findings		
	– The organization selected PIP variables and performance measures that were clear indicators of performance for both projects. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the PIP data and interpret the results for both projects. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. – The organization demonstrated statistically significant improvement that may be the result of its selected interventions for both projects. **Progress** – The PIP report included the planned frequency of data collection and data analysis. – The data collection plan was linked to the data analysis plan to ensure that appropriate data would be available for the PIP. – The organization conducted analysis in accordance with the data analysis plan. – The organization assessed the statistical significance of the difference between the initial and repeat measurements. – The organization utilized statistical testing to determine if there was statistical evidence that any observed improvement was the result of the interventions. **Recommendations** – Include the specific measures or results that were tested for statistical significance and statistical evidence in future reports.
Protocol 2: Validation of Performance Measures	**Strengths** – The organization demonstrated practices to ensure members receive pneumococcal vaccinations after the age of 65. **Progress** – No progress was identified in this review. **Recommendations** – Conduct a root cause analysis for the pneumococcal vaccination rate that declined from the prior review. The rate has declined for three consecutive years. Identifying the root cause or causes will allow the organization to focus improvement efforts. – Continue efforts to increase influenza vaccination rates. – Update influenza policies and procedures to include *DHS Technical Definitions* information related to COVID-19 not being an exclusion from receiving the influenza vaccine.
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	**Strengths** – The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected.

Lakeland Care, Inc.		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FC	FC: 7,294	4, 9, 10,13
Findings		
	– The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers **Progress** – The organization updated an internal policy and procedure with additional debarment guidance, specifically related to debarment verification of new providers, to include when there is a need for continuation of services and how the organization ensures it does not employ or contract with excluded providers in these circumstances. **Recommendations** – Ensure all disenrollment policies include the requirement to assist members whose enrollment ceases for any reason in obtaining transitional care. – Revise the process to disseminate practice guidelines to providers for consistency. – Develop and implement a procedure for verifying licensure/certification prior to contracting, and for ongoing monitoring, of providers who do not have an agency license and contract with their own licensed/certified practitioners.	
Protocol 9: Conducting Focused Studies of Health Care Quality *Sample Size* *FC: 261*	**Strengths** – Comprehensive assessment practices were strengths for the organization. – The organizations demonstrated strengths in assuring health and safety needs of members were satisfied. **Progress** – The organization focused efforts to improve the timeliness and comprehensiveness of assessments. **Recommendations** – Continue current monitoring and feedback practices and training efforts to ensure follow-up to member needs and services. – Focus efforts on improving the comprehensiveness of member-centered plans. – Focus efforts to improve consistency between the managed care organization's documentation and the *Long Term Care Functional Screen*. – Ensure rescreening with the *Long Term Care Functional Screen* is completed when members have a change in condition.	
Appendix V: Information Systems Capabilities Assessment	Not applicable. Reviewed in FY 21 - 22.	

My Choice Wisconsin, Inc.		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FC, FCP	FC: 15,242 FCP: 1,365	1, 2, 3, 5, 6, 8, 11, 12,14
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Clinical PIP: Health Equity* • *Nonclinical PIP: Caregiver Strain*	**Strengths** – The organization conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The organization clearly identified the PIP population in relation to the aim statement for both projects. – The organization selected PIP variables and performance measures that were clear indicators of performance for one project. – The organization used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The organization used appropriate techniques to analyze the PIP data and interpret the results for one project. – The organization selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. **Progress** – The PIP reports included the process and data sources related to collecting data that represented the study population. – The organization conducted tests of statistical significance to determine if any observed improvement was the result of the interventions. **Recommendations** – Identify time periods with start and end dates for all aim statements in future reports to ensure the aim statements are measurable. – Establish performance indicators or variables that are adequate to answer the PIP aim statements. – Consider and analyze factors that impact the comparability of data between initial and repeat measurements in future reports. – Continue to conduct methodologically sound projects to increase the probability of demonstrating improvement that was likely to be a result of the selected intervention. – Design future PIP projects to account for barriers to producing a true final rate for all aim statements, and ensure initial and repeat measures use the same methodology in order to be comparable. – Ensure consistency between the detailed inclusion/exclusion criteria for the study population and the population identified in the PIP aim statement.
Protocol 2: Validation of Performance Measures	**Strengths** – The organization demonstrated practices to ensure members receive pneumococcal vaccinations after the age of 65 in the Family Care and Family Care Partnership programs. **Progress** – No progress was identified in this review. **Recommendations**

My Choice Wisconsin, Inc.		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FC, FCP	FC: 15,242 FCP: 1,365	1, 2, 3, 5, 6, 8, 11, 12,14
Findings		
	– Conduct a root cause analysis for the Family Care and Family Care Partnership influenza vaccination rate that declined from the prior review. The rate declined for a third consecutive year in both programs. Identifying the root cause or causes will allow the organization to focus improvement efforts. – Continue efforts to increase influenza vaccination rates in both programs. – Continue efforts to increase pneumococcal vaccination rates.	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	**Strengths** – The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected. – The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. – The organization demonstrated the ability to ensure coordination and continuity of member care. – The organization conducts internal audits of the provider credentialing process to ensure accuracy and consistency, which creates interrater reliability among staff involved in the credentialing process. **Progress** – The organization implemented processes to monitor and maintain a network of appropriate long-term care service providers. – A procedure for verifying certification and licensure of all applicable ongoing providers was developed and implemented to ensure compliance with Department of Health Services-Managed Care Organization contract requirements. – Internal procedures were updated to include detailed debarment guidance, specifically related to debarment verification of new providers, providers with business names and owner names, and the monitoring process for ongoing providers. – The organization updated written guidance for staff and providers to include the specific reasons providers may advise or advocate for members, and educated staff and providers about this requirement. – The organization implemented systems to ensure restrictive measures tracking systems are adequately monitored and applications are sent to the Department of Health Services in a timely manner. – The member rights and advance directives policies were updated to include all requirements as outlined in the Department of Health Services-Managed Care Organization contract. – The organization developed advance directives training that is available to the community via the MCO's website. **Recommendations** – No recommendations identified for this review.	

<table>
<tr><th colspan="3">My Choice Wisconsin, Inc.</th></tr>
<tr><th>Programs Operated</th><th>FY 22-23 Enrollment by Program</th><th>GSRs</th></tr>
<tr><td>FC, FCP</td><td>FC: 15,242 FCP: 1,365</td><td>1, 2, 3, 5, 6, 8, 11, 12,14</td></tr>
<tr><th colspan="3">Findings</th></tr>
<tr><td>Protocol 9: Conducting Focused Studies of Health Care Quality
Sample Sizes
FC: 266
FCP: 227</td><td colspan="2">Strengths
– Comprehensive assessment practices were strengths for the Family Care program.
– The organization demonstrated strengths in assuring health and safety needs of members were satisfied in both programs.

Progress
– Focused efforts on improving care management practices resulted in several improvements for the Family Care Partnership program, including:
○ Timeliness of member assessments;
○ Timeliness of member-centered plans;
○ Comprehensiveness of member-centered plans; and
○ Member contact requirements.

Recommendations
– Continue efforts to improve the comprehensiveness of member-centered plans in the Family Care program.
– Continue efforts to improve the timeliness of member-centered plans in both programs.
– Ensure practices are in place to comply with essential provider requirements in the Family Care Partnership program.
– Focus efforts to ensure timely follow-up for effectiveness of services in both programs, especially needs related to members' medical care.
– Improve practices in the Family Care Partnership program to ensure routine contact occurs with members and other involved parties.
– Focus efforts to increase the consistency in documentation between the Long Term Care Functional Screen and the managed care organization documentation in both programs, and ensure rescreening is conducted when needed.</td></tr>
<tr><td>Appendix V: Information Systems Capabilities Assessment</td><td colspan="2">Strengths
– The organization has a strong system that is maintained and updated by a stable and experienced information system department.
– The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes.
– The organization's security systems met or exceeded most industry standards, ensuring consistent system and data availability.
– The organization's processes and system for collecting and maintaining administrative data and enrollment information ensured accurate encounter data is provided to the state.

Progress
– The organization was newly formed in January 2020. The evaluation conducted in FY 22-23 is the first evaluation conducted for the organization.</td></tr>
</table>

My Choice Wisconsin, Inc.		
Programs Operated	**FY 22-23 Enrollment by Program**	**GSRs**
FC, FCP	FC: 15,242 FCP: 1,365	1, 2, 3, 5, 6, 8, 11, 12,14
Findings		
	Recommendations – Explore the possibility of consolidating the number of systems the organization uses to manage claims processing, in order to improve efficiencies.	

Protocol 1: Validation of Performance Improvement Projects

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

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

The study methodology is assessed through the following steps:

- Review the selected 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 must seek DHS approval prior to beginning each project. For projects conducted during 2022, organizations submitted proposals to DHS in January 2022. DHS directed MCOs to submit final reports by December 30, 2022. MetaStar validated at least one clinical and at least one non-clinical PIP for each organization, for a total of ten PIPs. No topics were state-required in the current review cycle.

Overall PIP Results

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

validation rating reflects the EQRO's confidence in the PIP's methods and findings. See Appendix 2 for more information about the scoring methodology.

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

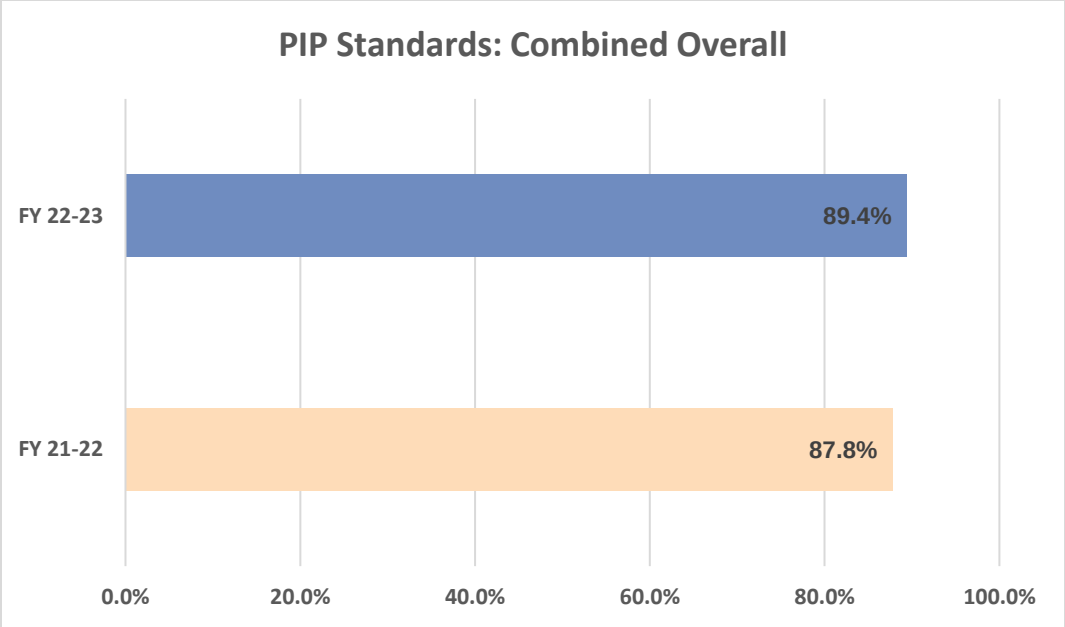
The following table lists each standard that was evaluated for each MCO, and indicates the total number of scoring elements and percentage of scoring elements met for each standard. The validation result for each standard is also included. Some standards are not applicable to all projects due to study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

The overall score for all projects validated in FY 22-23 was 89.4 percent, with a validation result of Moderate Confidence.

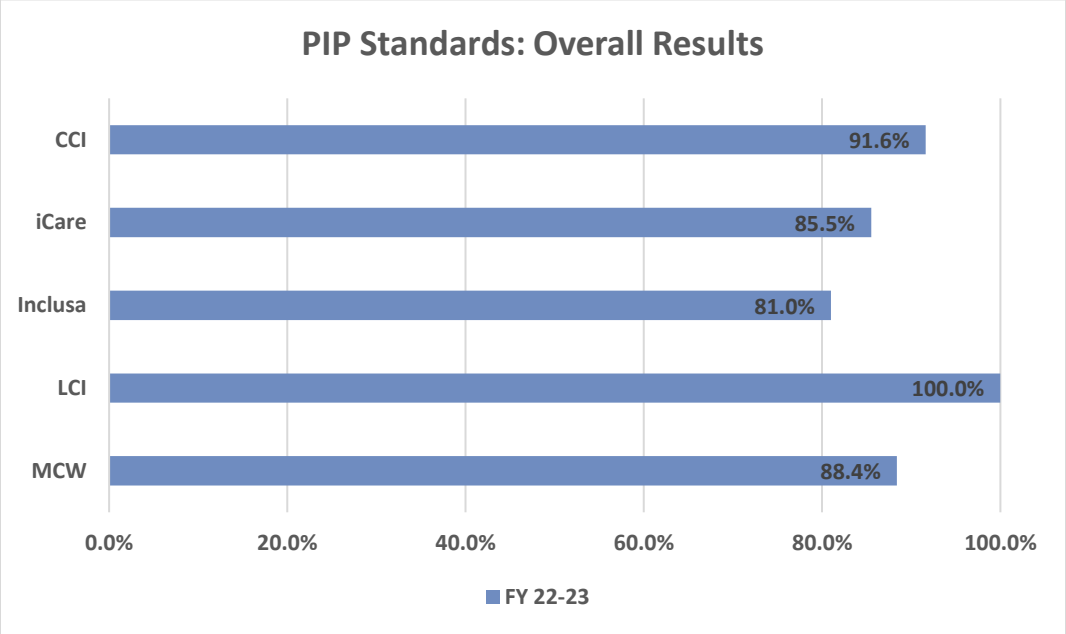
Performance Improvement Project Validation Review FY 22-23			
Standard	**Scoring Elements**	**Percentage**	**Validation Result**
Standard 1: PIP Topic	35/35	100.0%	High Confidence
Standard 2: PIP Aim Statement	50/60	83.3%	Moderate Confidence
Standard 3: PIP Population	17/20	85.0%	Moderate Confidence
Standard 4: Sampling Method*	N/A	N/A	N/A
Standard 5: PIP Variables and Performance Measures	55/57	96.5%	High Confidence
Standard 6: Data Collection Procedures	77/82	93.9%	High Confidence
Standard 7: Data Analysis and Interpretation of PIP Results	57/66	86.4%	Moderate Confidence
Standard 8: Improvement Strategies	54/60	90.0%	High Confidence
Standard 9: Significant and Sustained Improvement	26/35	74.3%	Low Confidence
Overall Score	**371/415**	**89.4%**	**Moderate Confidence**

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

The graph on the next page illustrates the State's overall compliance with these standards in FY 22-23 and compares the score to the same standards reviewed in FY 21-22.



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



Results for each PIP Standard

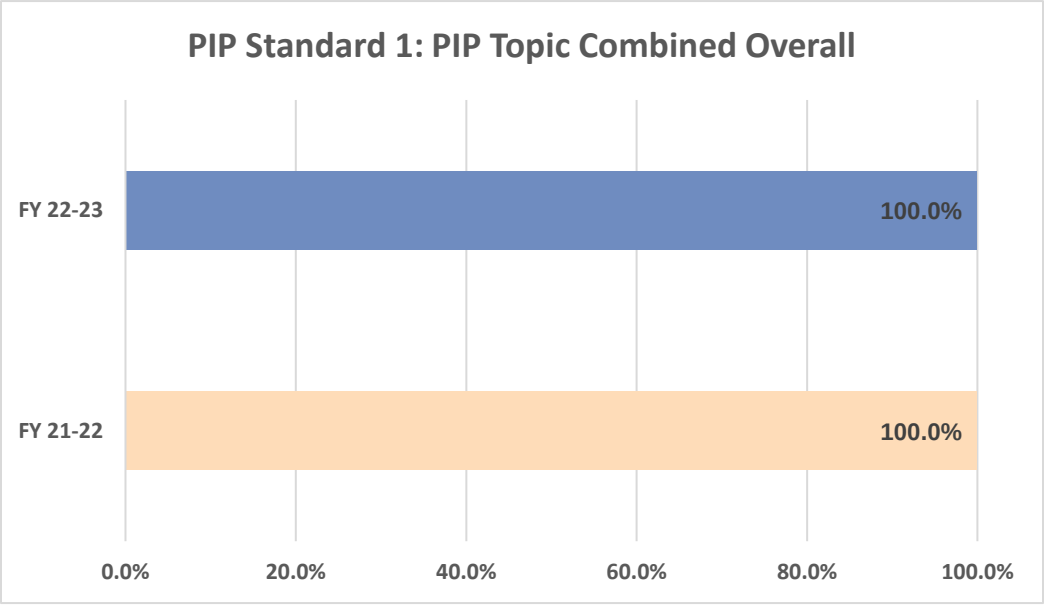
Each section that follows provides a brief explanation of the PIP standards, including rationale for any areas the MCOs were not fully compliant. Additionally, Appendix 3 includes results for each standard by MCO.

Observation and Analysis: Standard 1. PIP Topic

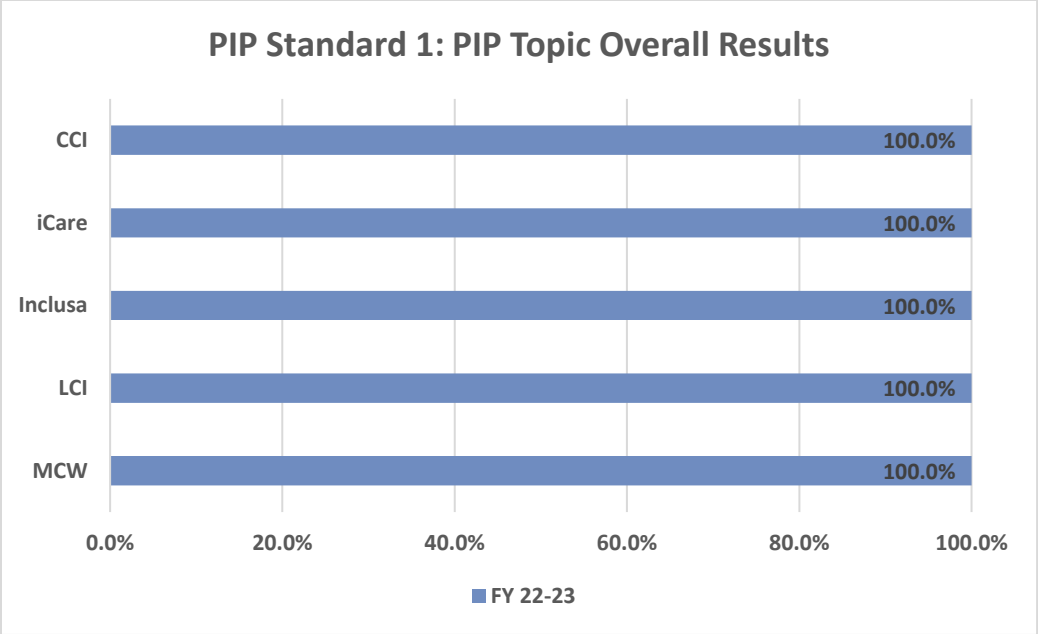
The MCOs should target improvement in relevant areas of clinical and non-clinical services. The topic selection process should consider the national Quality Strategy, CMS Core Set Measures, and DHS priorities. When appropriate or feasible, enrollee and provider input should be obtained. All topics should address areas of special populations or high priority services. Standard 1 evaluates each PIP on five possible scoring elements. Collectively, the MCOs satisfied requirements for35 out of 35 scoring elements, for a score of 100.0 percent.

All projects conducted and reported detailed research regarding project selection and its importance to members. Topics addressed priority areas and included enrollee and provider input when applicable.

The graph below illustrates the State's overall compliance with this standard in FY 22-23 and compares the score to the same standard reviewed in FY 21-22.



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



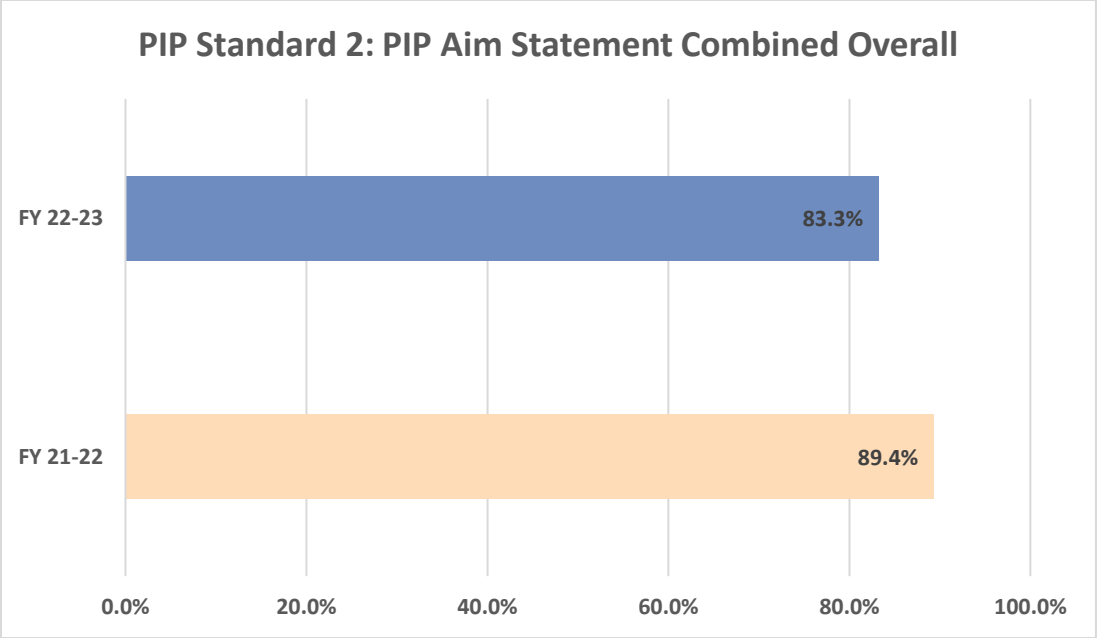
Observation and Analysis: Standard 2. PIP Aim Statement

The PIP aim statement identifies the focus of the PIP and establishes the framework for data collection and analysis. It should be a clear, concise, measurable, and answerable statement or question that identifies the improvement strategy, population, and time period. Standard 2 evaluates each PIP on six possible scoring elements. Collectively, the MCOs satisfied requirements for 50 out of 60 scoring elements, for a score of 83.3 percent.

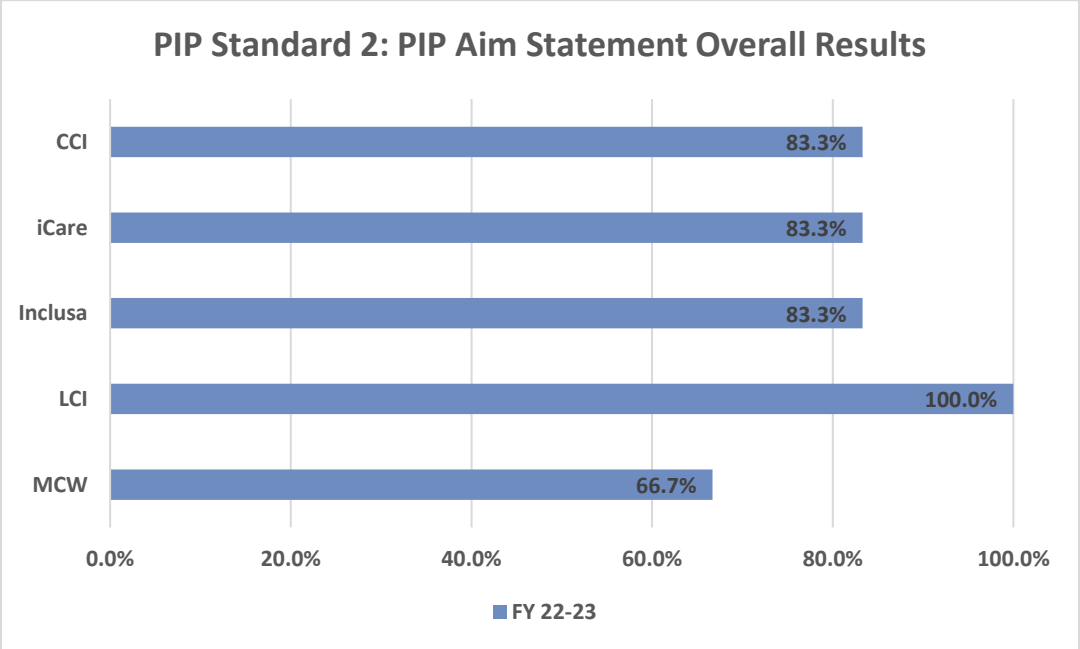
Scoring element 2.3 evaluated the time period for the project as part of each aim statement. Five projects did not clearly identify a starting date in the aim statement.

Scoring element 2.5 evaluated whether the aim statements are answerable. In order to be answerable, the aim must include improvement strategies, the population, and the time period. Since five projects did not include a start date, the aim statements were not answerable.

The graph on the next page illustrates the State's overall compliance with this standard in FY 22-23 and compares the score to the same standard reviewed in FY 21-22.



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

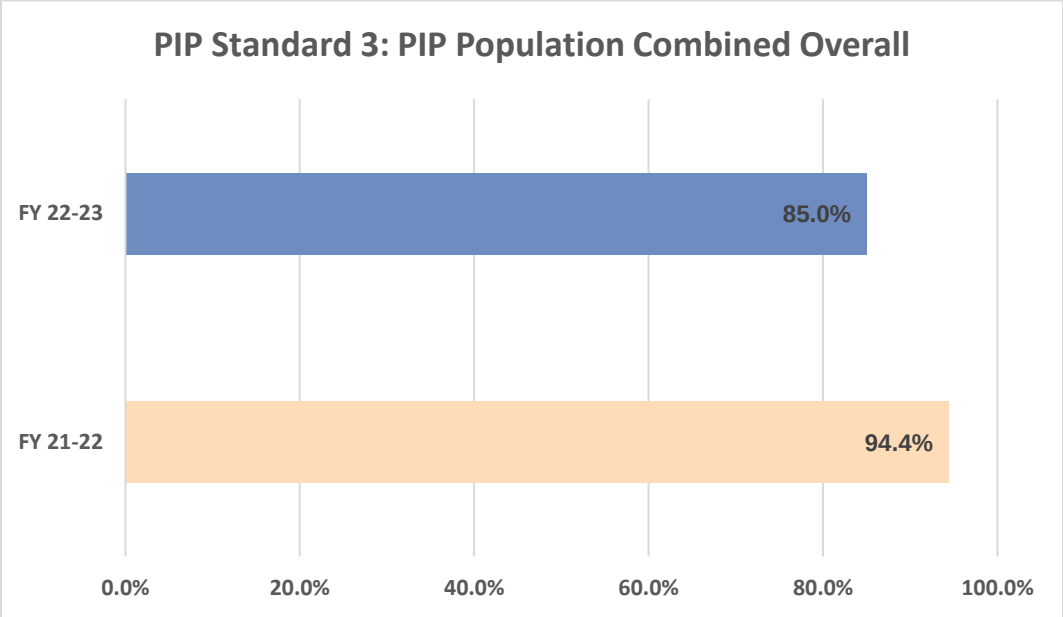


Observation and Analysis: Standard 3. PIP Population

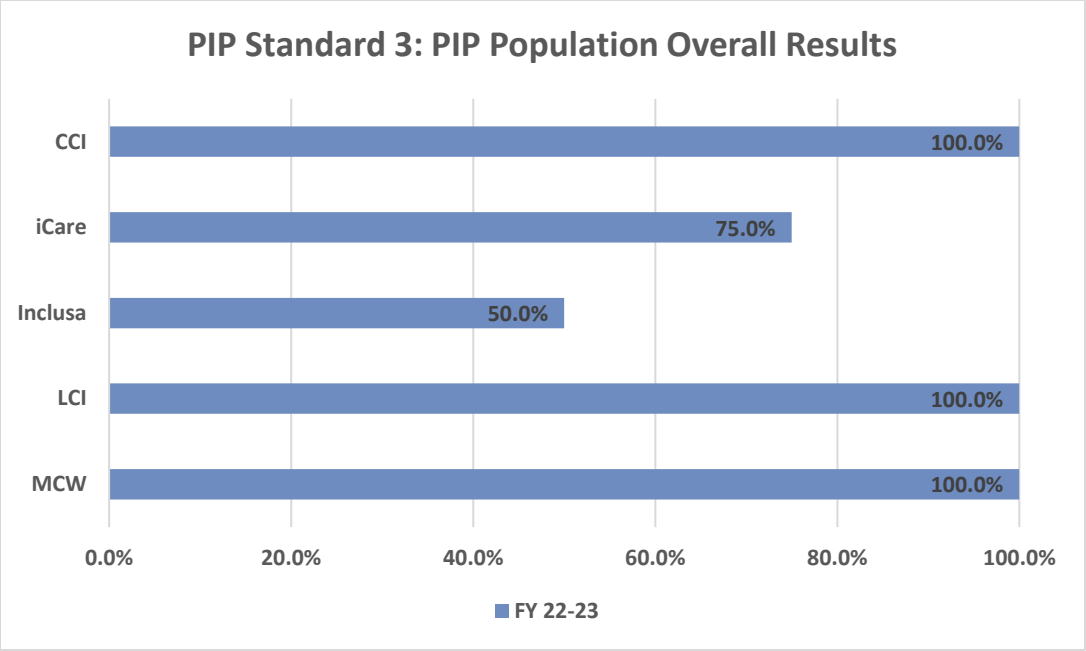
The MCOs must clearly define the project's population, identifying all inclusionary and exclusionary criteria. If the entire eligible MCOs population is included in the project, the data collection approach must ensure it captures all applicable members. Standard 3 evaluates each PIP on two possible scoring elements. Collectively, the organizations satisfied requirements for 17 out of 20 scoring elements, for a score of 85.0 percent.

The majority of projects clearly defined the PIP population as it related to the aim statement. Scoring element 3.1 assesses that the PIP project population was clearly defined in terms of the identified PIP question. Two projects did not include a clear description of the project populations. Almost all projects documented a data collection approach that captured all members to whom the PIP question applied.

The graph below illustrates the State's overall compliance with this standard in FY 22-23 and compares the score to the same standard reviewed in FY 21-22.

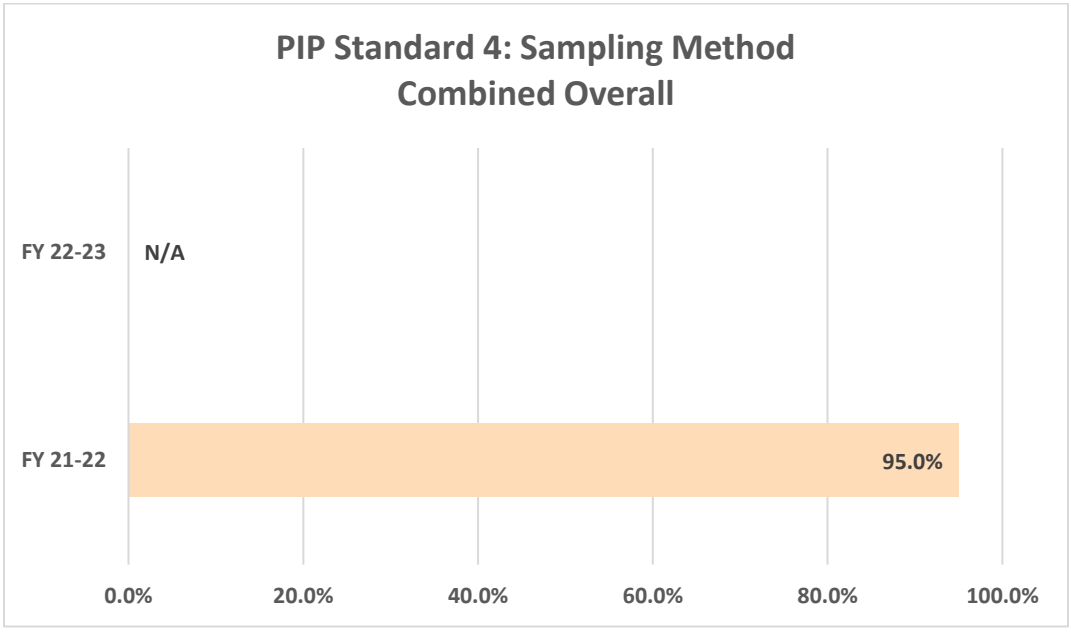


The graph on the next page illustrates each MCO's overall compliance with this standard.



Observation and Analysis: Standard 4. Sampling Method

The MCOs must have appropriate sampling methods to ensure data collection produces valid and reliable results. Sampling was not used for any projects in FY 22-23.

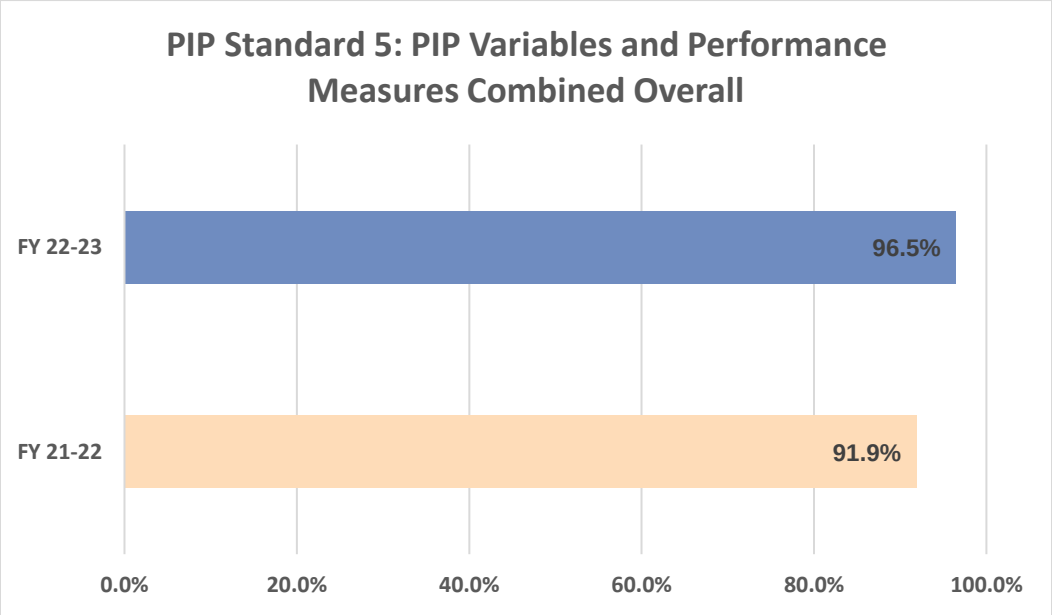


Observation and Analysis: Standard 5. PIP Variables and Performance Measures

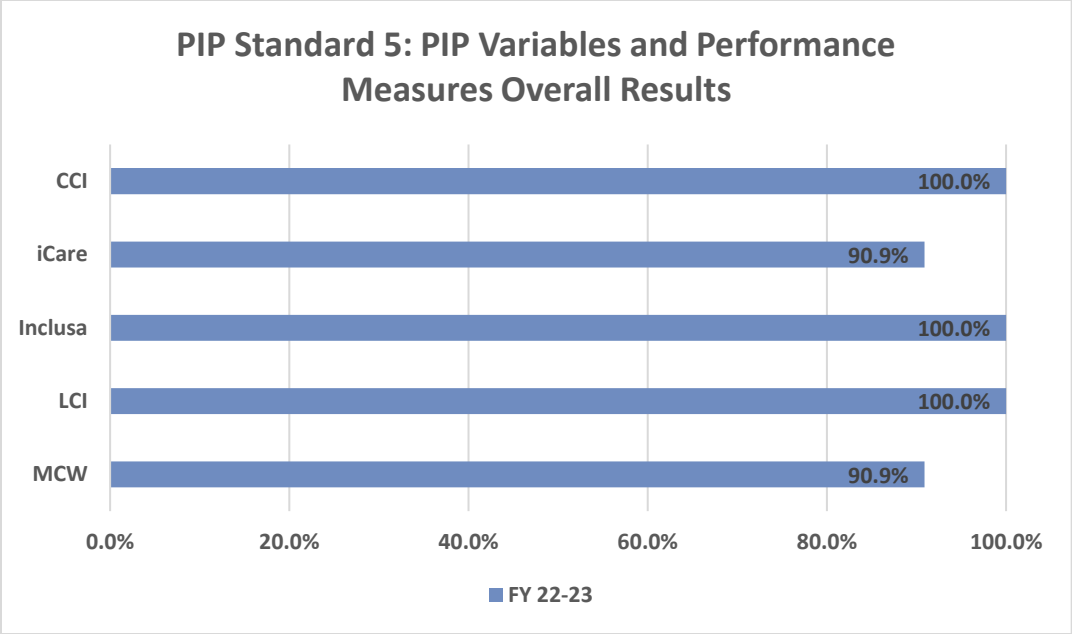
MCOs must select variables that identify the MCO's performance on the PIP questions objectively and reliably, using clearly defined indicators of performance. The PIP should include the number and type of variables that are adequate to answer the PIP question, can measure performance, and can track improvement over time. Standard 5 evaluates each PIP on 10 possible scoring elements. Collectively, the MCOs satisfied requirements for 55 out of 57 scoring elements, for a score of 96.5 percent.

Almost all projects used PIP variables and performance measures that were clear indicators of performance and were adequate to answer the PIP aim statements. Most projects included a strategy to ensure inter-rater reliability for performance measures when required.

The graph below illustrates the State's overall compliance with this standard in FY 22-23 and compares the score to the same standard reviewed in FY 21-22.



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



Observation and Analysis: Standard 6. Data Collection Procedures

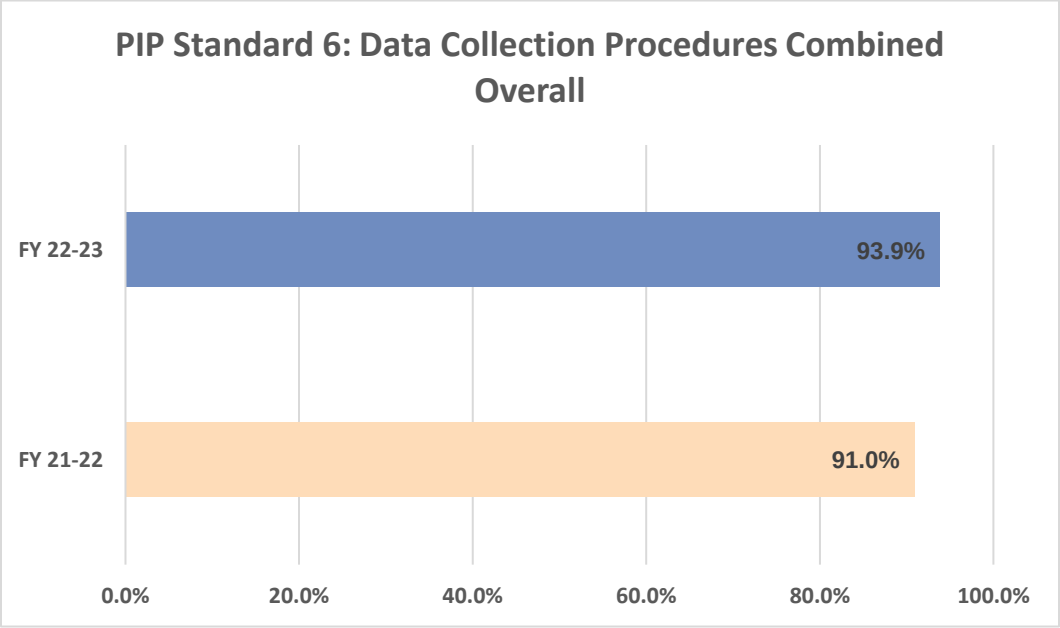
MCOs must establish data collection procedures that ensure valid and reliable data throughout the project. The data collection plan should specify the following:

- 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.

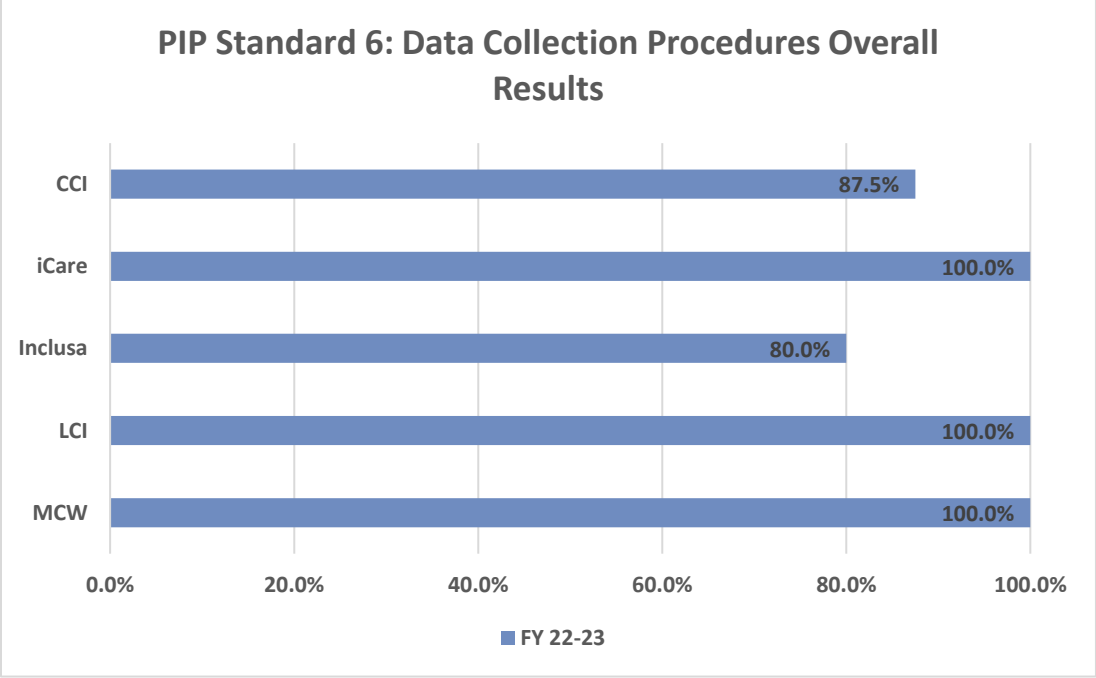
Standard 6 evaluates each PIP on 16 possible scoring elements. Collectively, the MCOs satisfied requirements for 77 out of 82 scoring elements, for a score of 93.9 percent.

The majority of projects detailed data collection process to ensure that appropriate data would be available for the PIP. Two of the projects did not include the frequency of the data collection which resulted in the data collection plan not aligning with the data analysis plan. Additional reasons for projects not meeting the requirements were that one plan did not identify the data sources and another plan did not have a systematic system for collecting data.

The graph on the next page illustrates the State's overall compliance with this standard in FY 22-23 and compares the score to the same standard reviewed in FY 21-22.



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



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 evaluates each PIP on eight possible scoring elements. Collectively, the MCOs satisfied requirements for 57 out of 66 scoring elements, for a score of 86.4 percent.

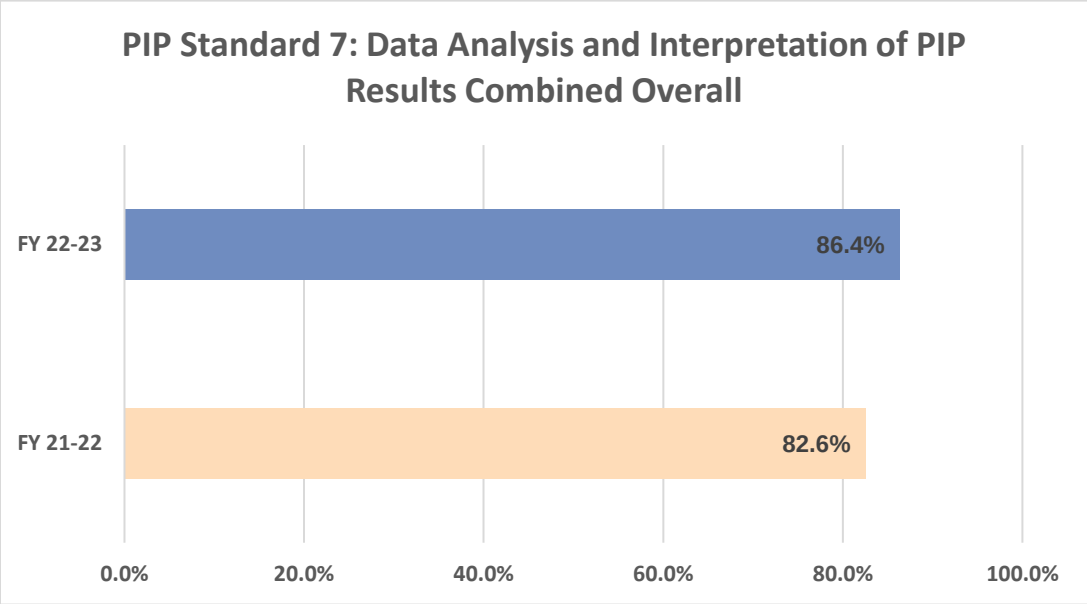
Almost all projects completed their data analysis according to their data analysis plan.

Scoring element 7.4 evaluates whether the analysis accounted for factors that may influence the comparability of initial and repeat measurements. Two projects did not take these factors into consideration during the analysis of the project outcomes.

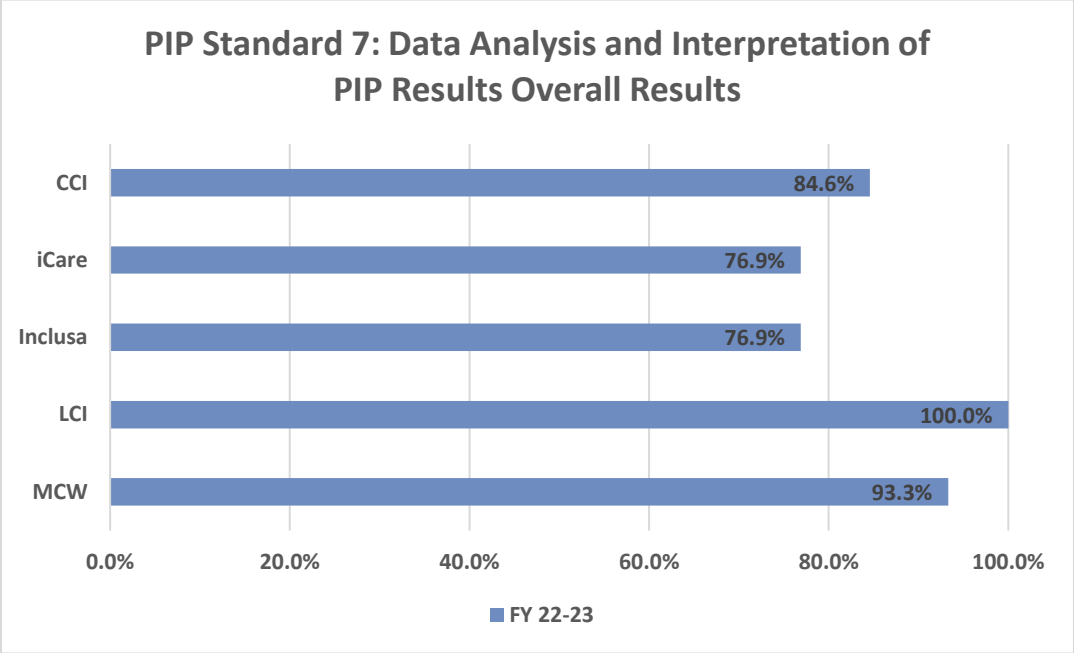
Scoring element 7.6 evaluates if the projects compared results across multiple entities or subgroups. Three of the projects failed to compare the results due to a misunderstanding that the comparison can be done within the MCO and does not have to be external.

Scoring element 7.7 assesses that the PIP results were presented in a concise and easily understood manner. Two of the projects did not meet this requirement due to presenting data inconsistently or inaccurately.

The graph below illustrates the State's overall compliance with this standard in FY 22-23 and compares the score to the same standard reviewed in FY 21-22.



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

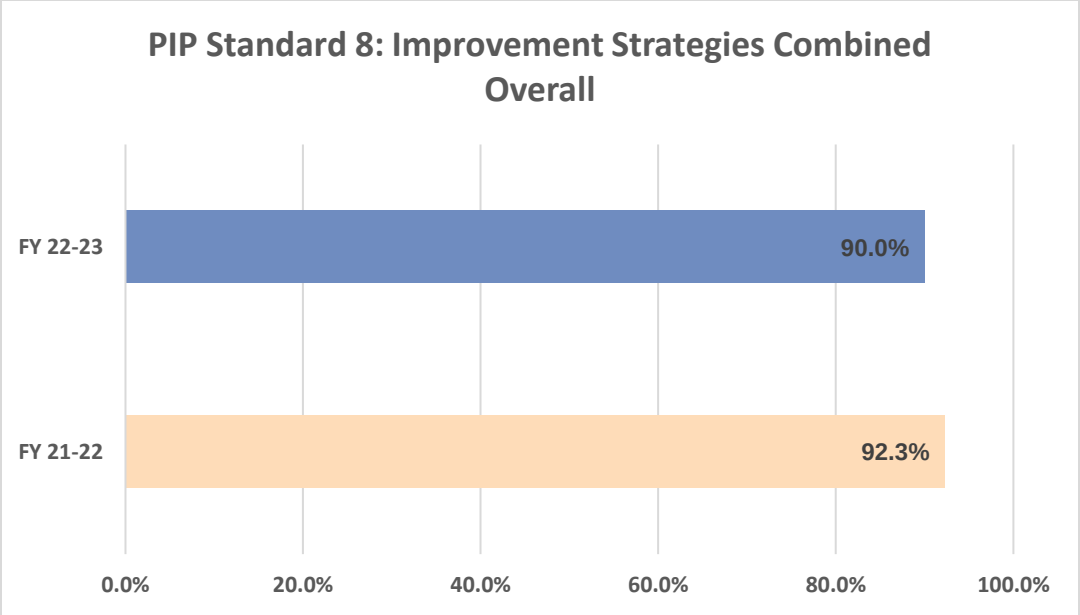


Observation and Analysis: Standard 8. Improvement Strategies

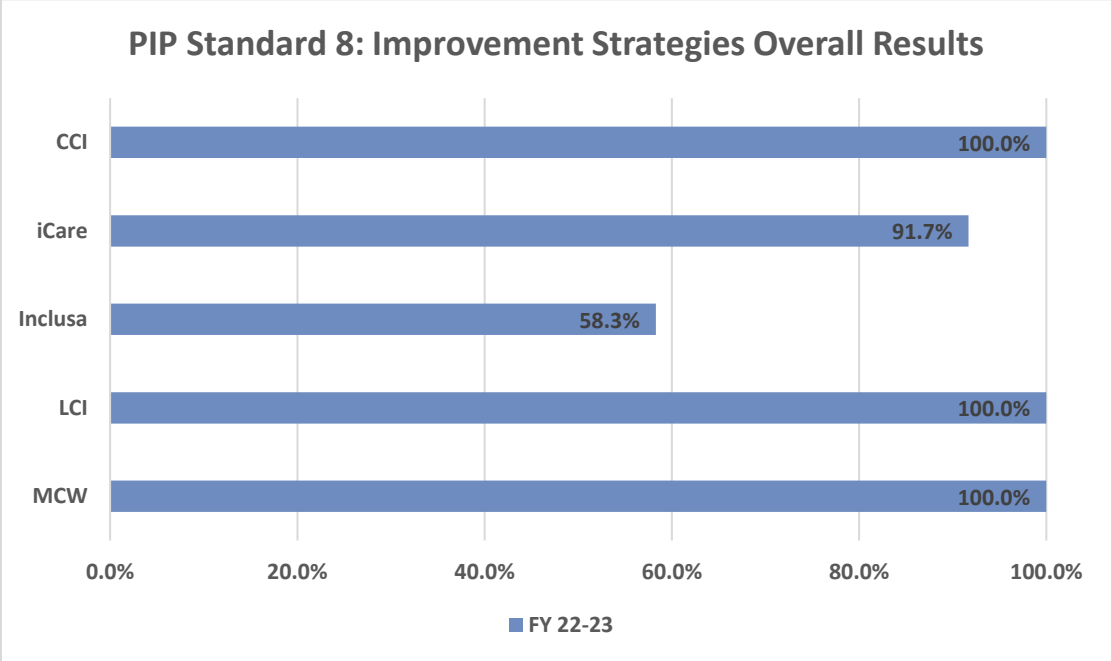
MCOs should select improvement strategies that are evidence-based, suggesting they would likely lead to the desired improvement. The effectiveness of the strategies are determined by measuring the change in performance according to the measures identified in Standard 5. Standard 8 evaluates each PIP on six possible scoring elements. Collectively, the MCOs satisfied requirements for 54 out of 60 scoring elements, for a score of 90.0 percent.

Almost all projects included evidence to support that the selected interventions would lead to change and used improvement strategies designed to address barriers encountered while analyzing the data. Most projects included the use of Plan Do Study Act cycles during project implementation. Almost all projects included information on how the project was culturally and linguistically appropriate.

The graph on the next page illustrates the State's overall compliance with this standard in FY 22-23 and compares the score to the same standard reviewed in FY 21-22.



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



Observation and Analysis: Standard 9. Significant and Sustained Improvement

An important component of a PIP is to demonstrate sustained improvement. The 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 26 out of 35 scoring elements, for a score of 74.3 percent.

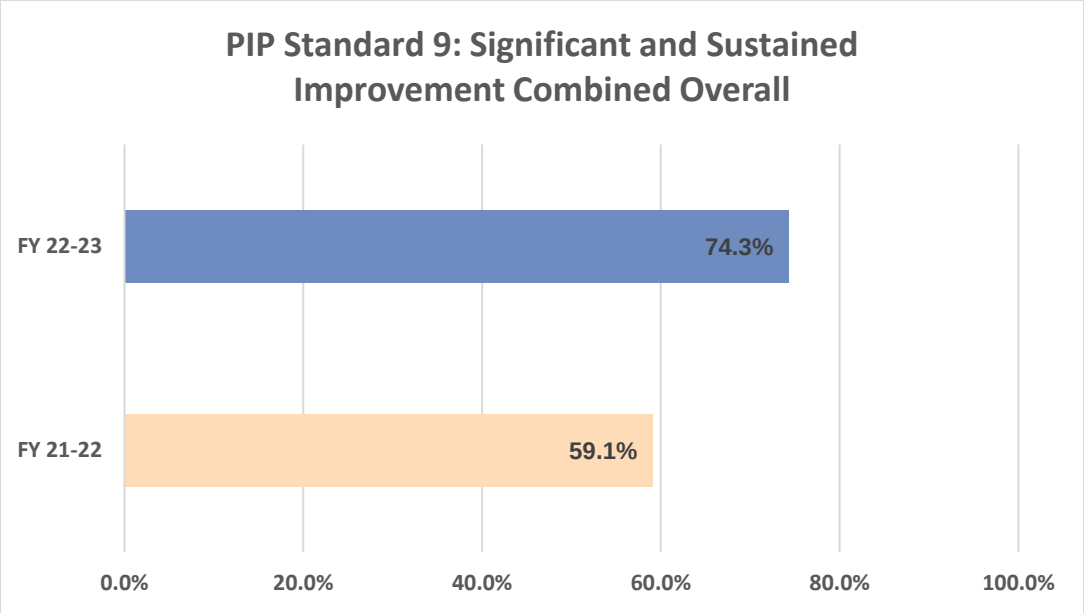
Scoring element 9.1 evaluates using the same methodology for the project's baseline and repeat measurements. There were two projects that did not use the same methodology for each measurement.

Scoring element 9.2 evaluates if there was qualitative evidence of improvement. Improvement could not be evaluated in the two projects that used different methodology in the baseline and repeat measurement; therefore this scoring element was not satisfied.

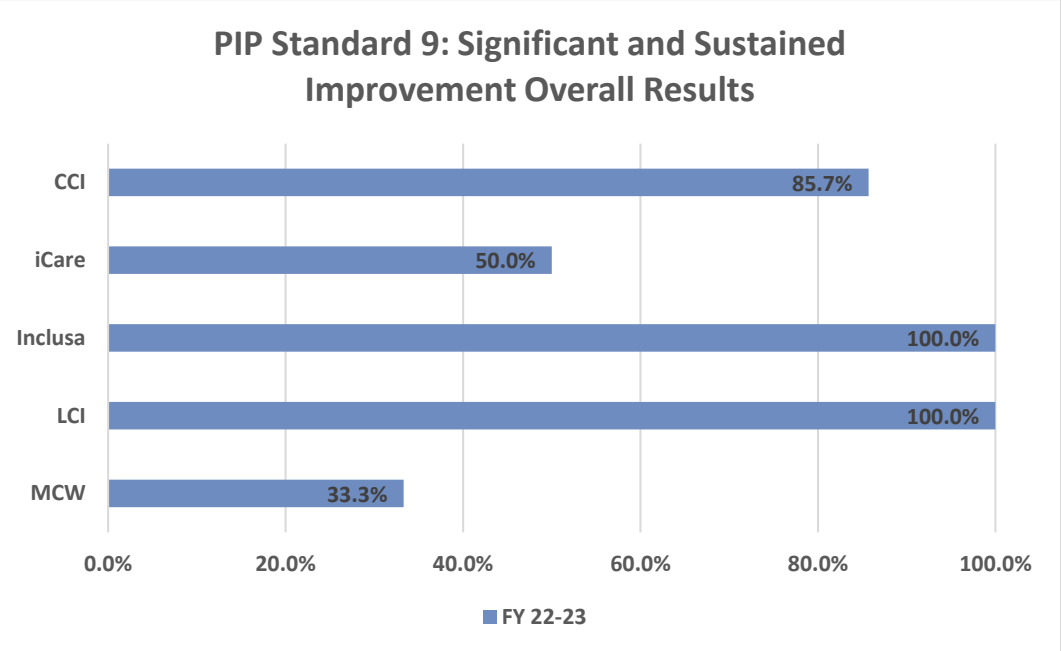
Scoring element 9.3 assesses if the reported improvement in performance was likely to be the result of the selected intervention. This was not able to be evaluated in the two projects that used different methodology in the baseline and repeat measurement; therefore this scoring element was not satisfied. A third project did not address if the improvement was due to the interventions.

Scoring element 9.4 evaluates if there is statistical evidence that the observed improvement is the result of the intervention. Due to the lack of comparability between measures, valid statistical testing could not be completed. A third project did not include statistical evidence in the report.

The graph on the next page illustrates the State's overall compliance with this standard in FY 22-23 and compares the score to the same standard reviewed in FY 21-22.



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



Conclusions

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

Protocol 2: Validation of Performance Measures

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

The MCO quality indicators for MY 2022, which are set forth in Addendum III of the 2022 DHS-MCO contract, provide standardized information about preventive health services and continuity of care. As directed by DHS, MetaStar validated the completeness and accuracy of MCOs' influenza and pneumococcal vaccination data for MY 2022. The technical definitions provided by DHS for the MY influenza and pneumococcal vaccination quality indicators include a definition of the MY. The technical definitions can be found in Attachments 1 and 2. The review methodology MetaStar used to validate these performance measures are in Appendix 2.

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

Vaccination Rates by Program and MCO

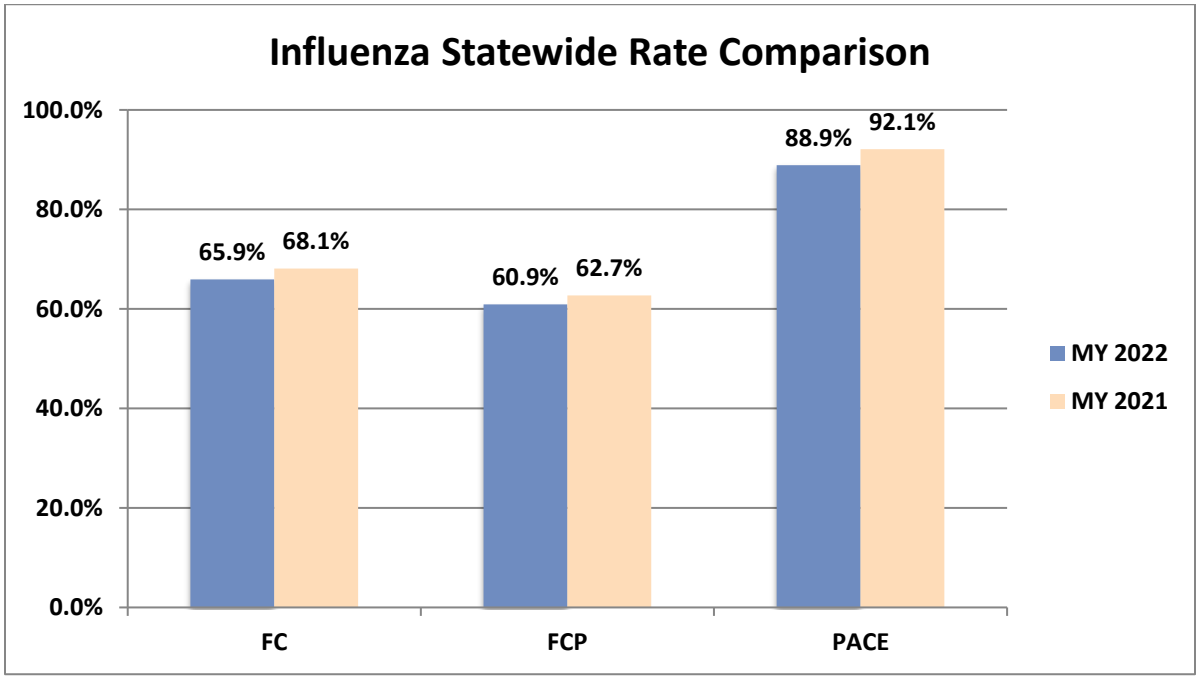
The results of statewide performance for immunization rates in FC, FCP, and PACE are summarized below.

Influenza Vaccination Rates

The following table shows information about the influenza vaccination rates, by program, for MY 2022 and compares the MY 2022 rates to vaccination rates in MY 2021.

Statewide Influenza Vaccination Rates by Program				
	MY 2022			MY 2021
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	45,880	30,251	65.9%	68.1%
Family Care Partnership	3,235	1,971	60.9%	62.7%
PACE	433	385	88.9%	92.1%

Influenza vaccination statewide rates, by program, for MY 2022 and MY 2021 are shown in the following graph.

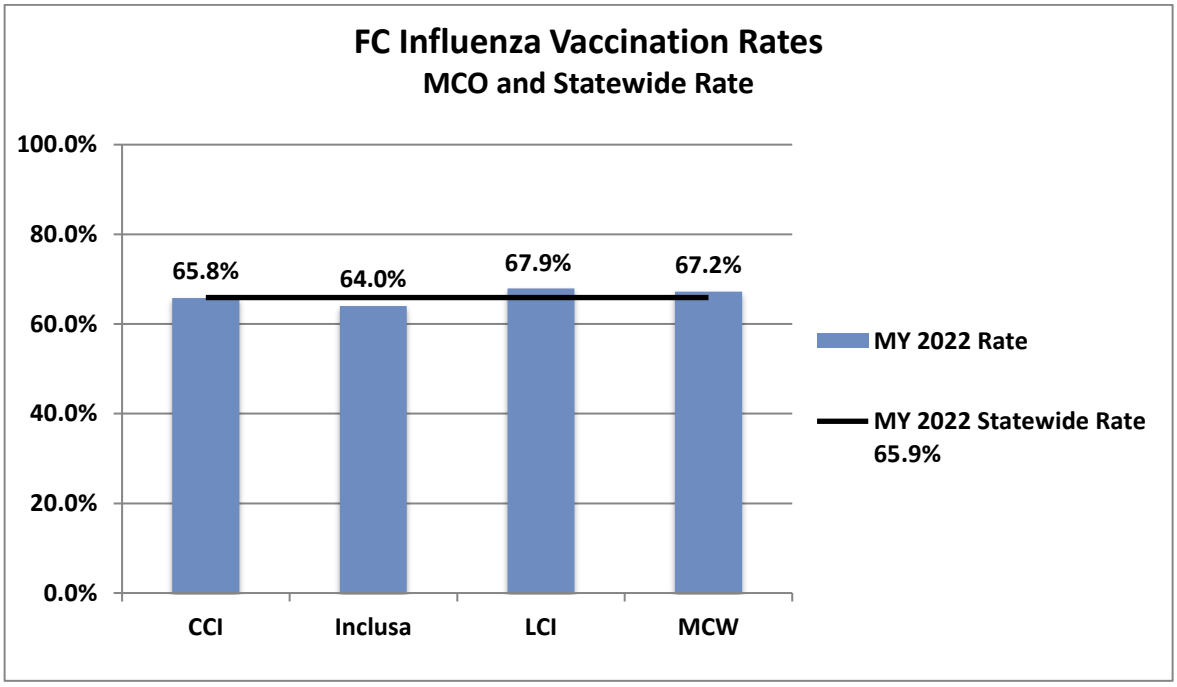


The following table shows influenza vaccination rates by program and MCO for MY 2022 and MY 2021. MY 2021 influenza vaccination rates were amended after the issuance of the final reports due to an error in the data. Rates reflected in this report are the amended rates.

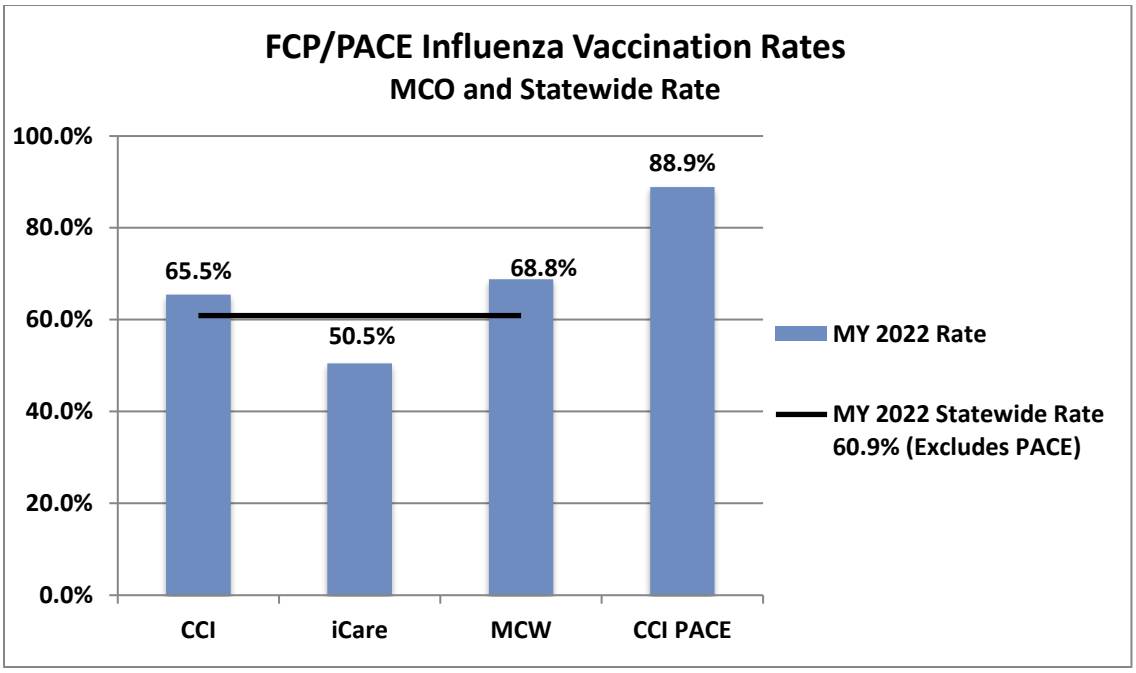
Influenza Vaccination Rates by Program and Measurement Year				
Program/MCO	MY 2022			MY 2021
	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care				
CCI	11,524	7,580	65.8%	66.9%
Inclusa	14,398	9,213	64.0%	68.2%

Influenza Vaccination Rates by Program and Measurement Year				
Program/MCO	MY 2022			MY 2021
	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
LCI	6,496	4,410	67.9%	69.2%
MCW	13,462	9,048	67.2%	68.8%
Family Care Partnership				
CCI	660	432	65.5%	64.6%
*i*Care	1,271	642	50.5%	51.1%
MCW	1,304	897	68.8%	71.6%
PACE				
CCI	433	385	88.9%	92.1%

The graph below includes the influenza vaccination rates among the FC MCOs.



The graph on the next page compares the influenza vaccination rates among the MCOs operating FCP and PACE. Only one MCO operates the PACE program; therefore, here and in subsequent graphs in this report, no PACE statewide rate is available for comparison.



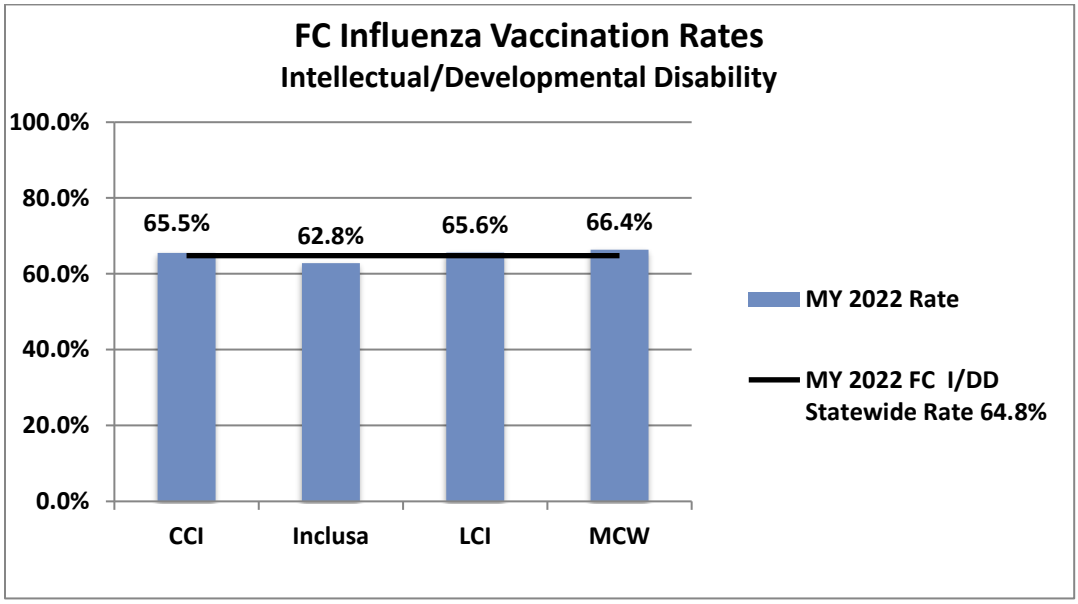
Influenza Vaccination Rates by Target Group

For each program (FC, FCP, and PACE), influenza vaccination rates varied by target group as shown in the table below.

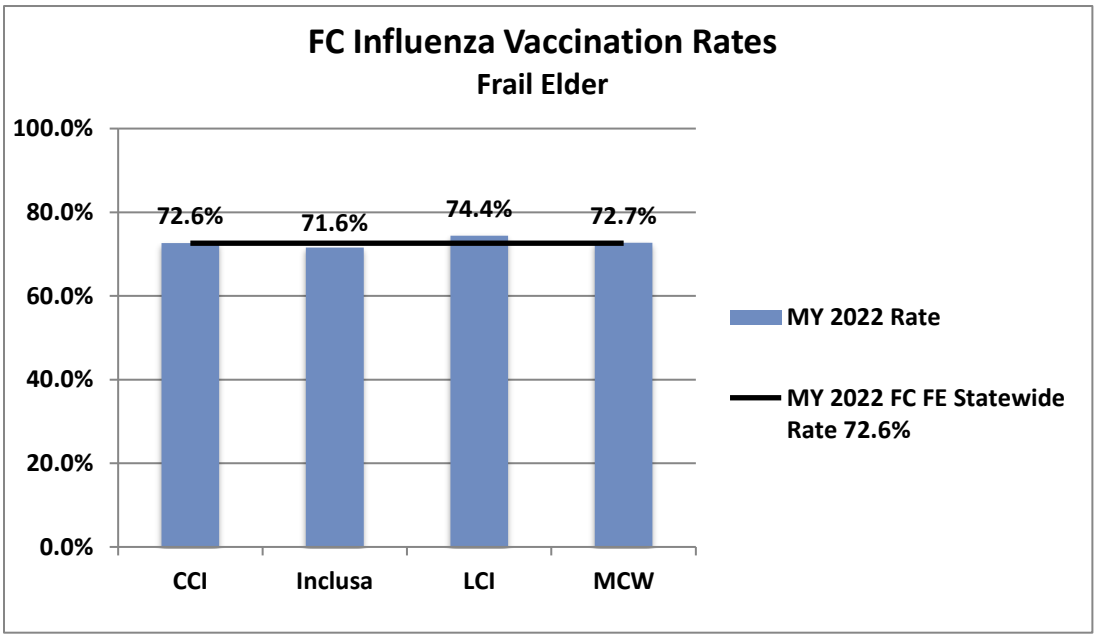
MY 2022 Influenza Vaccination Rates by Program and Target Group			
Program/Target Group	**Eligible Members**	**Number Vaccinated**	**Vaccination Rate**
Family Care			
Intellectual/Developmental Disability	22,349	14,491	64.8%
Frail Elder	15,746	11,427	72.6%
Physical Disability	7,785	4,333	55.7%
Family Care Partnership			
Intellectual/Developmental Disability	858	516	60.1%
Frail Elder	1,147	807	70.4%
Physical Disability	1,230	648	52.7%
PACE			
Intellectual/Developmental Disability	51	44	86.3%
Frail Elder	359	326	90.8%
Physical Disability	23	15	65.2%

Family Care

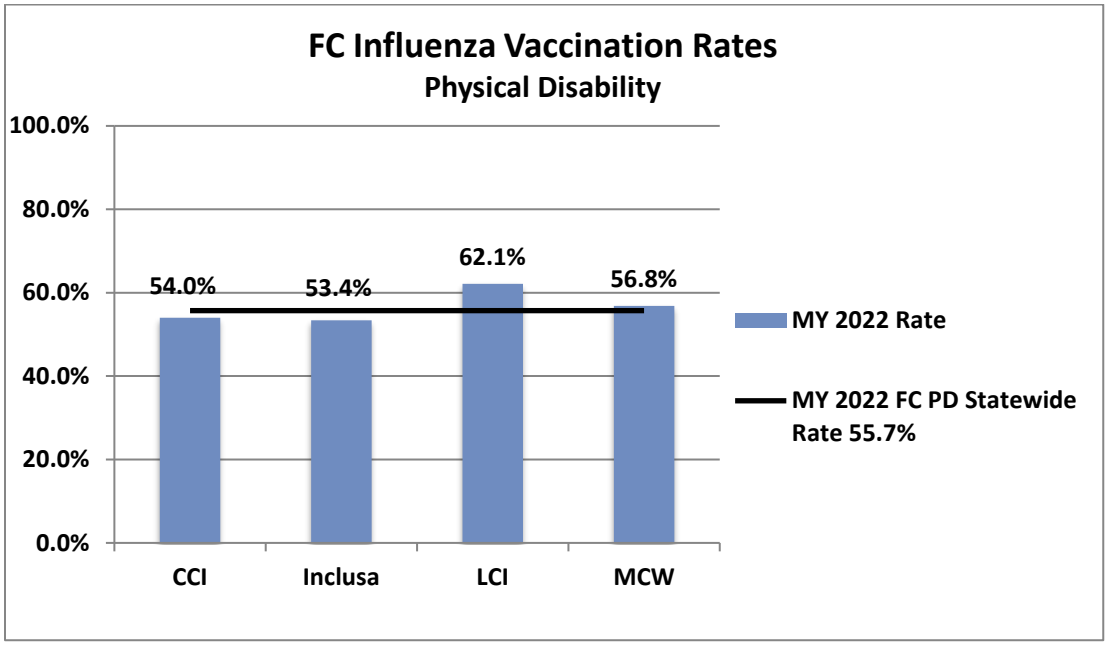
The graph below shows influenza vaccination rates for FC members in the Intellectual/ Developmental Disability target group, by MCO, for MY 2022.



The graph below shows influenza vaccination rates for FC members in the Frail Elder target group, by MCO, for MY 2022.

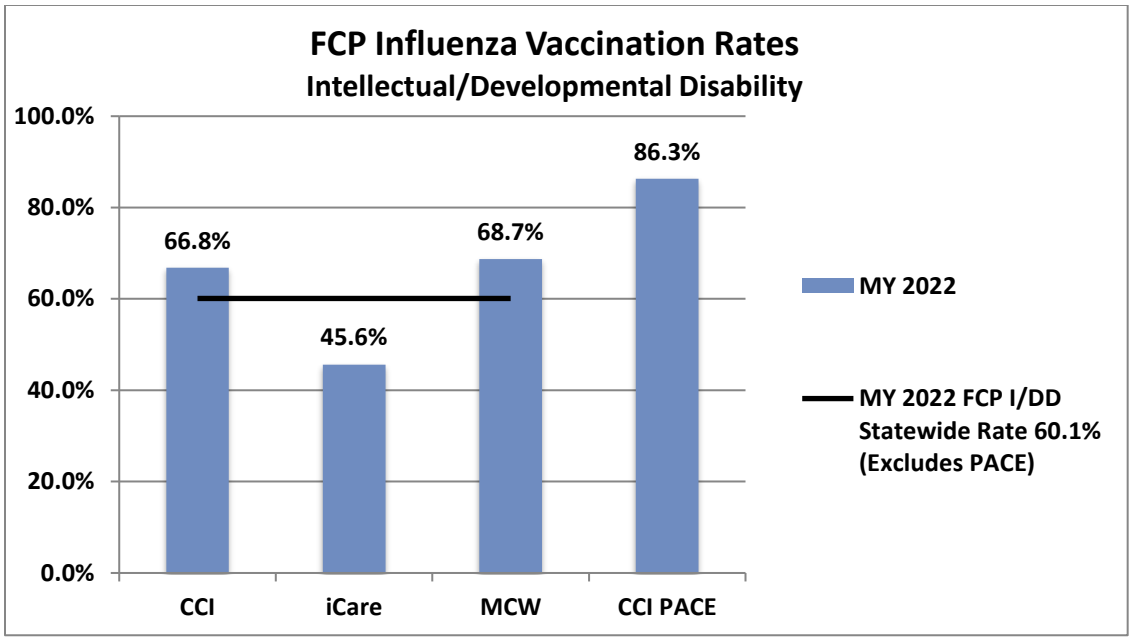


The graph below shows influenza vaccination rates for FC members in the Physical Disability target group, by MCO, for MY 2022.

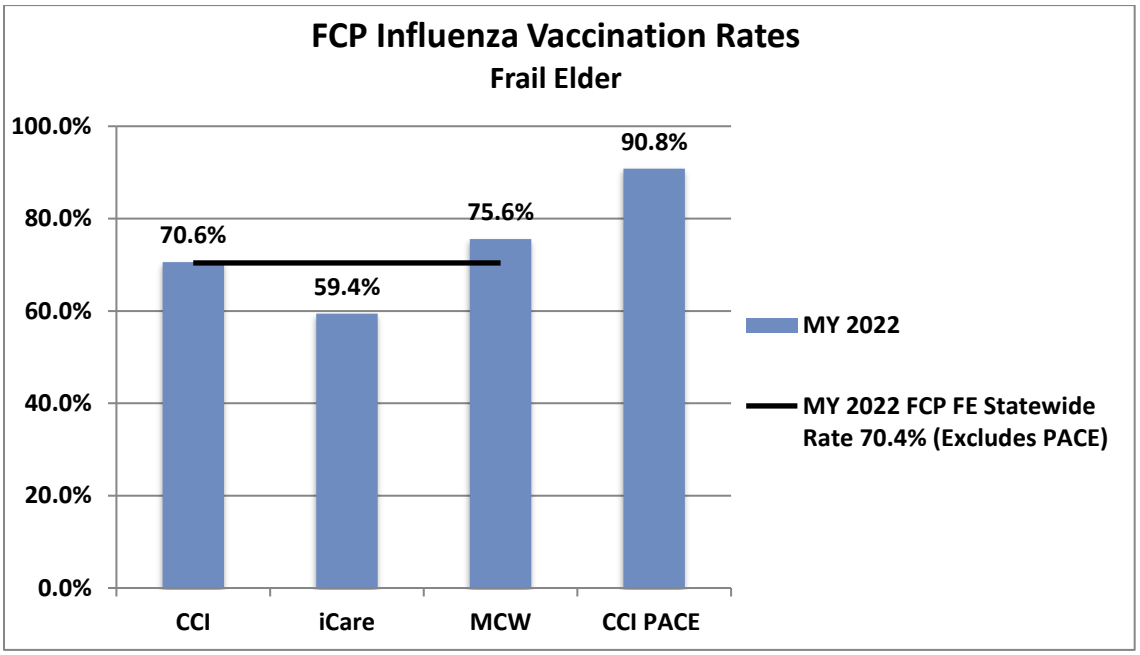


Family Care Partnership/PACE

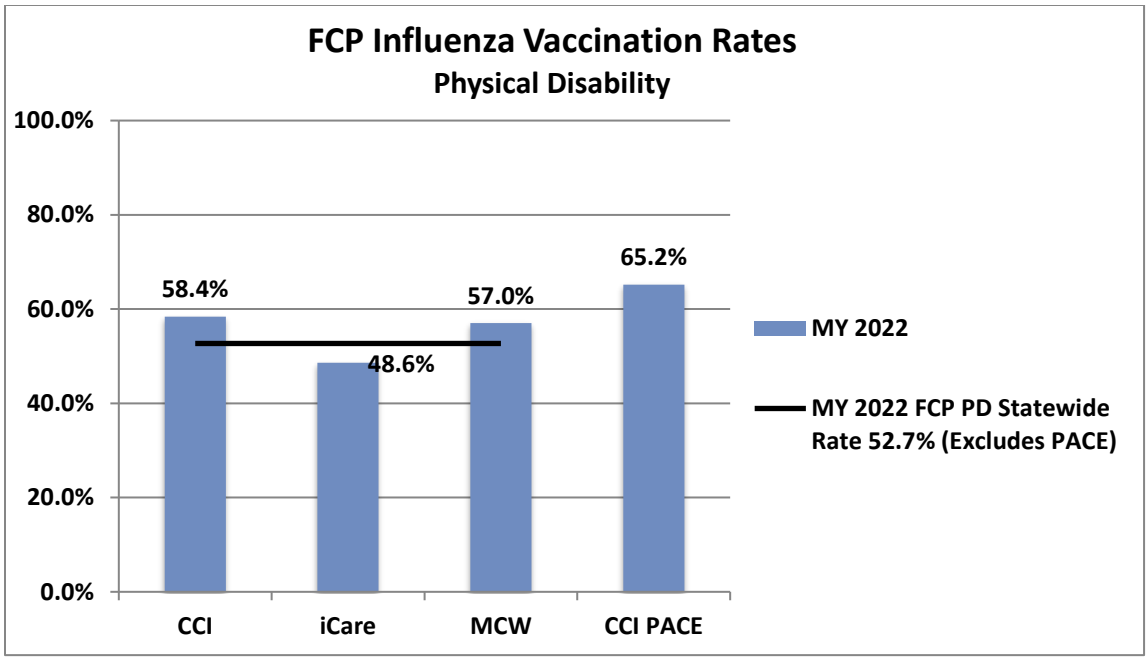
The graph on the next page shows influenza vaccination rates for FCP and PACE members in the Intellectual/Developmental Disability target group, by MCO, for MY 2022.



The following graph shows influenza vaccination rates for FCP and PACE members in the Frail Elder target group, by MCO, for MY 2022.



The graph on the next page shows influenza vaccination rates for FCP and PACE members in the Physical Disability target group, by MCO, for MY 2022.

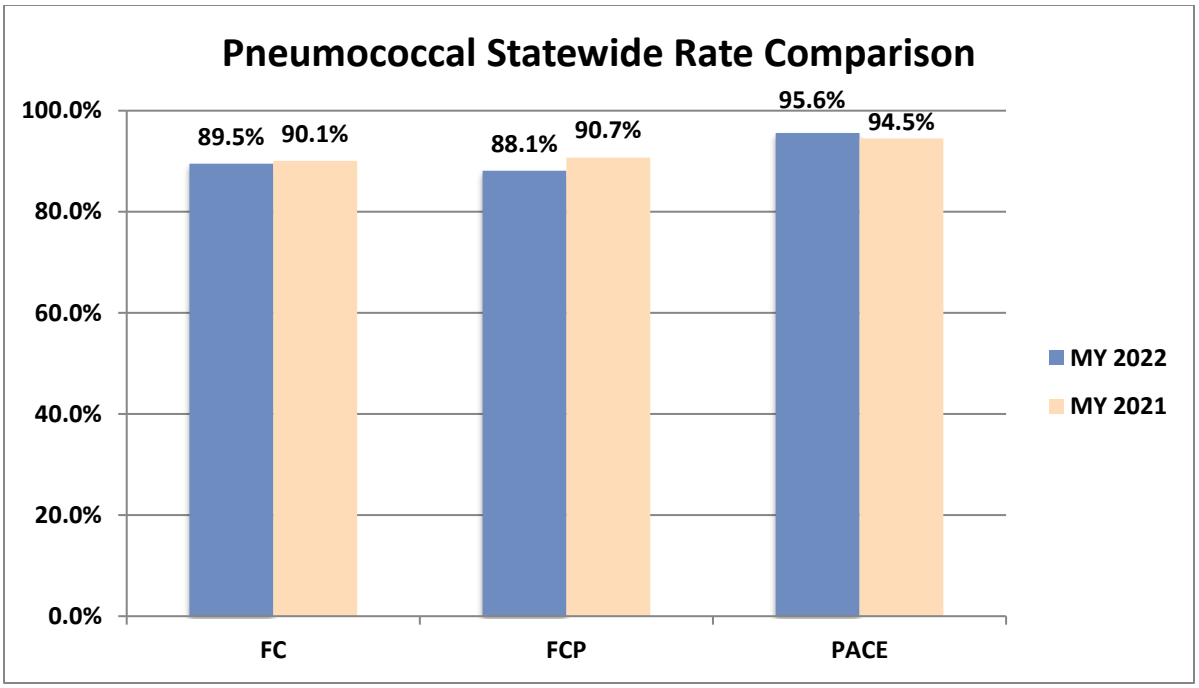


Pneumococcal Vaccination Rates

The table below shows information about the pneumococcal vaccination rates, by program, for MY 2022 and compares the MY 2022 rates to vaccination rates in MY 2021.

Statewide Pneumococcal Vaccination Rates by Program				
	MY 2022			MY 2021
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	20,697	18,515	89.5%	90.1%
Family Care Partnership	1,351	1,190	88.1%	90.7%
PACE	410	392	95.6%	94.5%

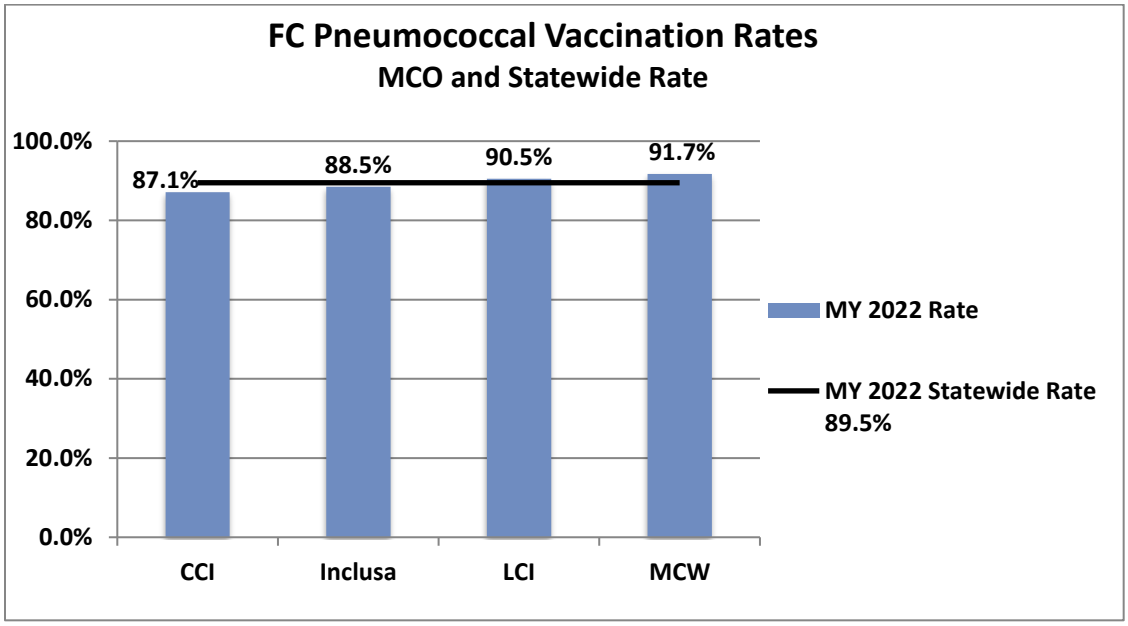
Pneumococcal vaccination statewide rates, by program, for MY 2022 and MY 2021 are shown in the following graph.



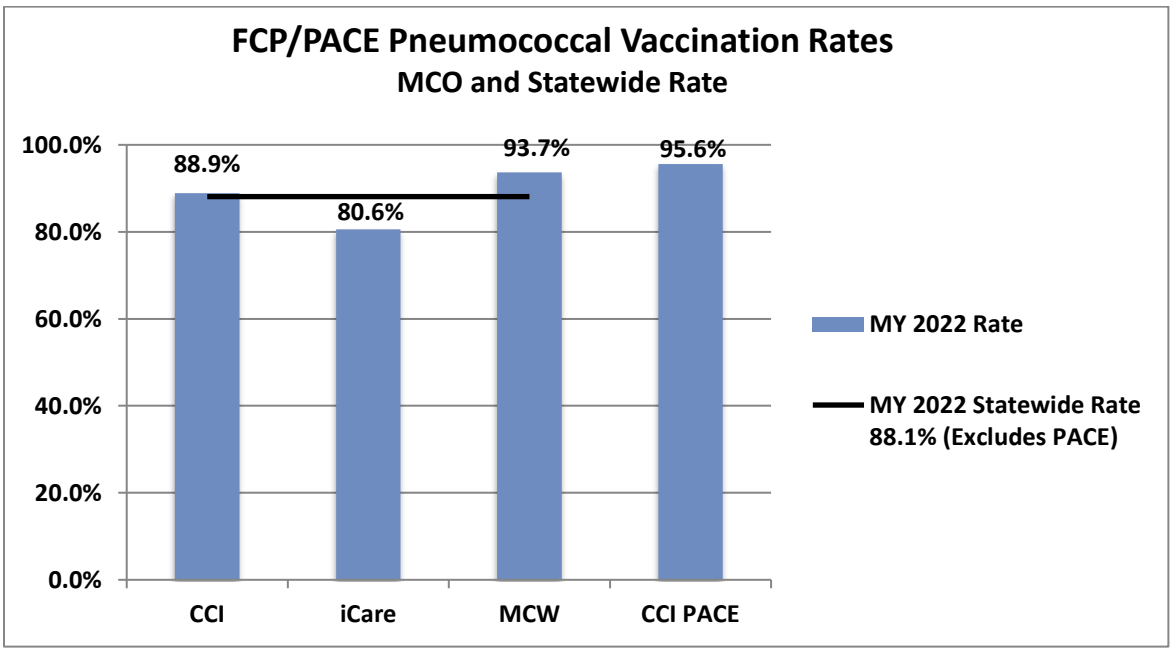
The following table shows pneumococcal vaccination rates by program and MCO for MY 2022 and MY 2021.

Pneumococcal Vaccination Rates by Program and Measurement Year				
Program/MCO	MY 2022			MY 2021
	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care				
CCI	5,054	4,403	87.1%	85.5%
Inclusa	6,276	5,556	88.5%	90.4%
LCI	2,767	2,504	90.5%	92.0%
MCW	6,600	6,052	91.7%	92.0%
Family Care Partnership				
CCI	234	208	88.9%	85.5%
*i*Care	464	374	80.6%	90.4%
MCW	744	697	93.7%	92.0%
PACE				
CCI	410	392	95.6%	94.5%

The graph below includes the pneumococcal vaccination rates among the FC MCOs.



The graph below includes the pneumococcal vaccination rates among the MCOs operating FCP and PACE. As noted earlier in this report, only one MCO operates the PACE program; therefore, no PACE statewide rate is available for comparison.



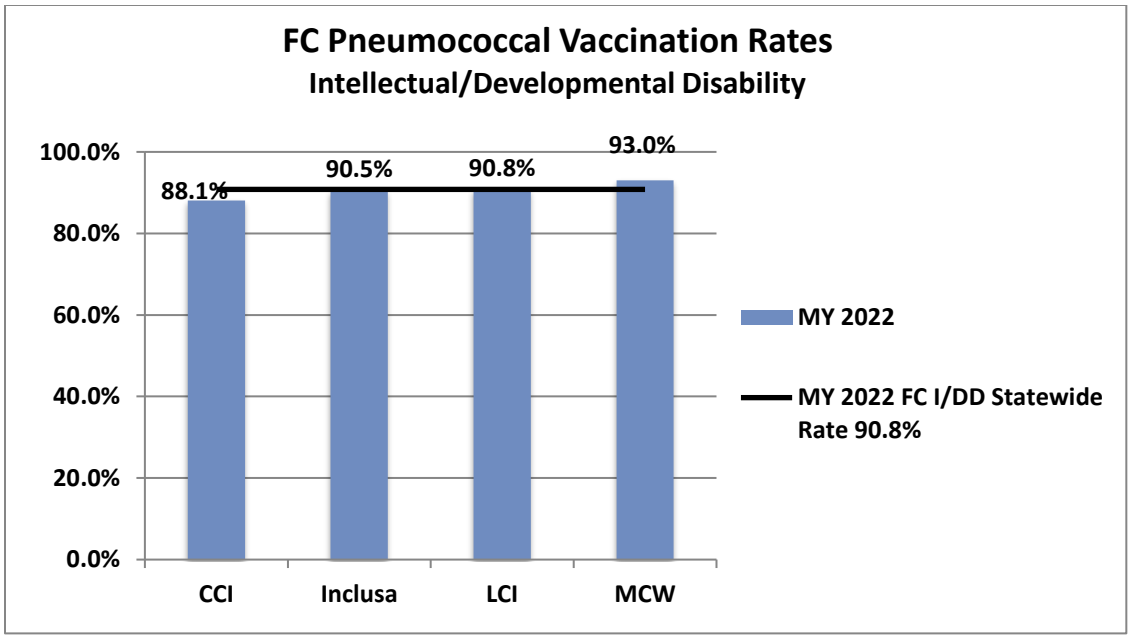
Pneumococcal Vaccination Rates by Target Group

For each program (FC, FCP, and PACE), vaccination rates varied by target group as shown in the table below. All people who have a physical disability (PD) target group and are age 65 or older are assigned to the frail elder (FE) target group. People who are in the intellectual/ developmental disability (I/DD) target group remain in the I/DD target group regardless of age. This is due to the target group automation for the *Adult Long Term Care Functional Screen* (LTCFS) implemented by DHS in 2017. There is no PD target group for the pneumococcal vaccination rates, as all included members are over the age of 65, per the DHS technical definitions. Any members incorrectly assigned to the PD target group by the MCOs were reassigned to the FE target group by MetaStar for this report.

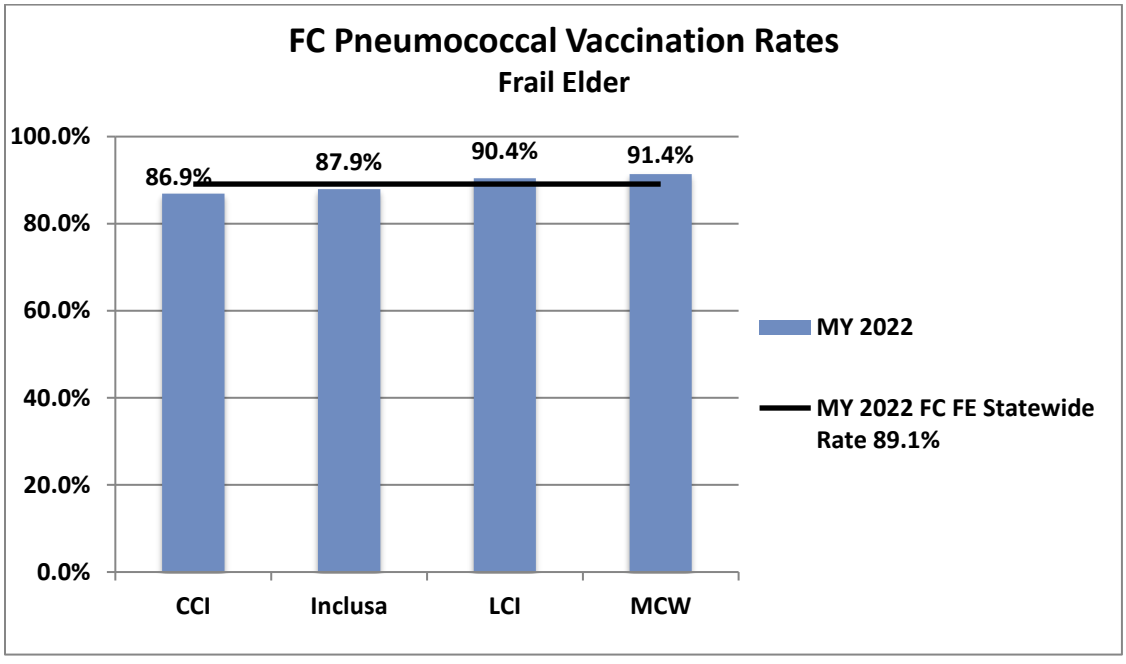
MY 2022 Pneumococcal Vaccination Rates by Program and Target Group			
Program/Target Group	**Eligible Members**	**Number Vaccinated**	**Vaccination Rate**
Family Care			
Intellectual/Developmental Disability	4,158	3,774	90.8%
Frail Elder	16,539	14,741	89.1%
Family Care Partnership			
Intellectual/Developmental Disability	175	163	93.1%
Frail Elder	705	597	84.7%
PACE			
Intellectual/Developmental Disability	35	35	100.0%
Frail Elder	375	357	95.2%

Family Care

The following graph shows pneumococcal vaccination rates for FC members in the Intellectual/ Developmental Disability target group, by MCO, for MY 2022.

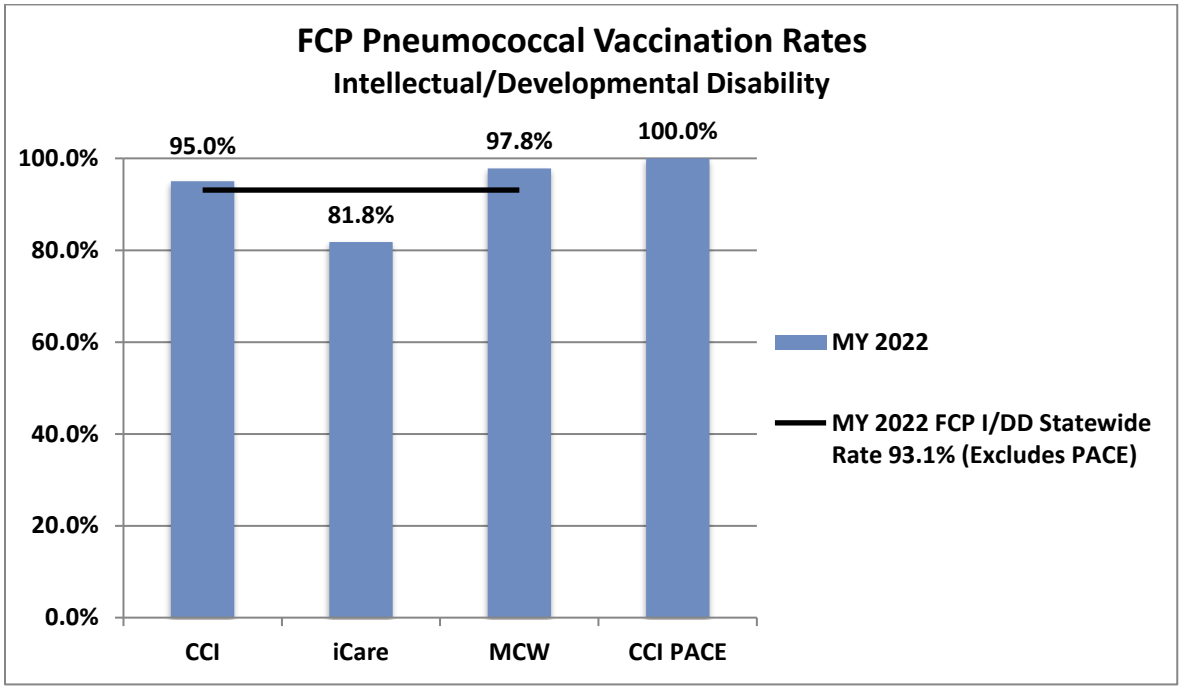


The graph below shows pneumococcal vaccination rates for FC members in the Frail Elder target group, by MCO, for MY 2022.

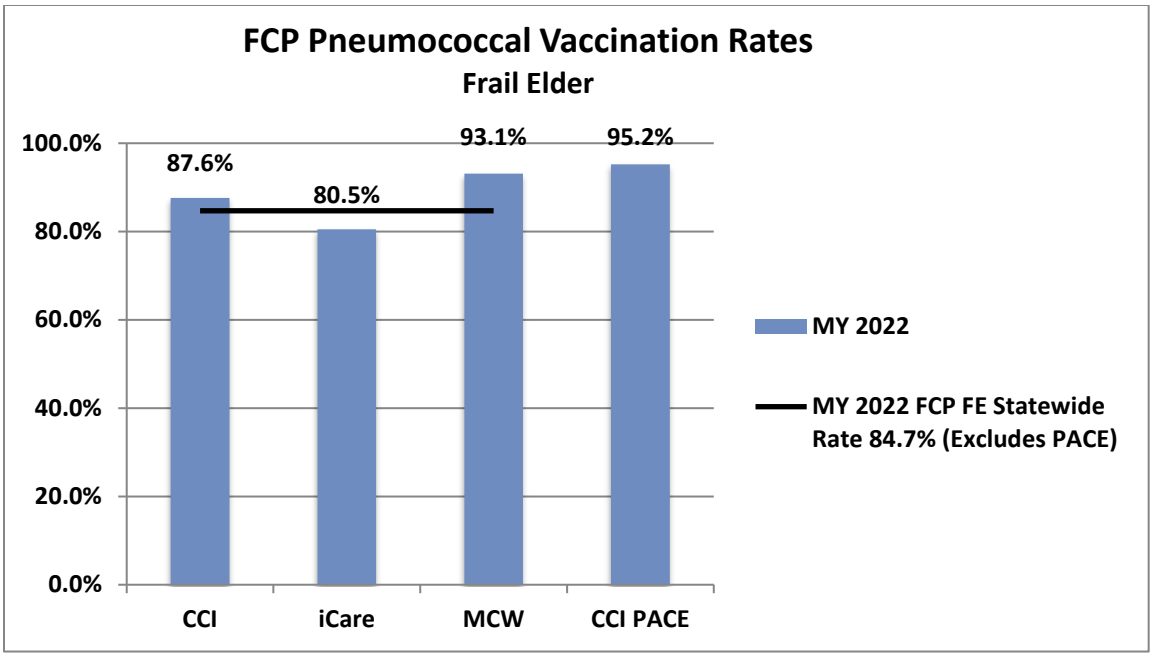


Family Care Partnership/PACE

The graph below shows pneumococcal vaccination rates for FCP and PACE members in the Intellectual/Developmental Disability target group, by MCO, for MY 2022.



The graph on the next page shows pneumococcal vaccination rates for FCP and PACE members in the Frail Elder target group, by MCO, for MY 2022.



Comparison of MCO and DHS Denominators

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

For all MCOs and quality indicators, more than 99 percent of the total number of unique members included in the MCOs and DHS' denominator files were common to both data sets. All MCOs were within the five percentage point threshold established by DHS in their initial submissions.

Vaccination Record Validation

To validate the MCOs' influenza and pneumococcal vaccination data, MetaStar requested 30 records of randomly selected members per quality indicator for each program the MCO operated during MY 2022. Whenever possible, the samples included 25 members reported to have received a vaccination and five members reported to have a contraindication to the vaccination.

As shown in the following tables, MetaStar reviewed a total of 240 member vaccination records for each quality indicator for MY 2022. The member records were reviewed to verify documentation of vaccinations, exclusions, and contraindications as defined by the technical

definitions. The records were determined to be valid for accurate documentation, or invalid for inaccurate documentation. A T-test, a type of statistical test, was conducted to determine if the data was biased or not biased.

The overall findings for the *Quality Indicator: Influenza Vaccination* for MY 2022 were unbiased, meaning the rates can be accurately reported.

The overall findings for the *Quality Indicator: Pneumococcal Vaccination* for MY 2022 were unbiased, meaning the rates can be accurately reported.

The overall findings from MY 2021 are included for informational purposes.

Vaccination Record Validation Aggregate Results

MY 2022 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	240	239	99.6%	Unbiased
Pneumococcal Vaccinations	240	240	100.0%	Unbiased
MY 2021 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	240	240	100.0%	Unbiased
Pneumococcal Vaccinations	240	240	100.0%	Unbiased

Vaccination Record Validation Individual MCO Results

The following tables provide information about the validation findings for each MCO in MY 2022.

Results for Influenza Vaccination

MY 2022 Influenza Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCI	30	30	100.0%	Unbiased
Inclusa	30	30	100.0%	Unbiased
LCI	30	30	100.0%	Unbiased
MCW	30	30	100.0%	Unbiased
Family Care Partnership				
CCI	30	30	100.0%	Unbiased
*i*Care	30	29	96.6%	Unbiased
MCW	30	30	100.0%	Unbiased

MY 2022 Influenza Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
PACE				
CCI	30	30	100.0%	Unbiased

Results for Pneumococcal Vaccination

MY 2022 Pneumococcal Vaccination Record Validation by Program and MCO				
MCO	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Family Care				
CCI	30	30	100.0%	Unbiased
Inclusa	30	30	100.0%	Unbiased
LCI	30	30	100.0%	Unbiased
MCW	30	30	100.0%	Unbiased
Family Care Partnership				
CCI	30	30	100.0%	Unbiased
*i*Care	30	30	100.0%	Unbiased
MCW	30	30	100.0%	Unbiased
PACE				
CCI	30	30	100.0%	Unbiased

Technical Definition Compliance

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

Vaccination Policies and Procedures

MetaStar reviewed each MCO's policies and procedures related to educating members on the benefits of vaccinations. All policies included guidance for identifying and documenting vaccination outcomes, such as received, refused, or contraindicated.

Conclusions

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

Protocol 3: Compliance with Standards – Quality Compliance Review

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

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

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

The 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 MCO. The first year of the cycle includes the MCO Standards, followed by QAPI and Grievance Standards in the second year.

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

Overall QCR Results by MCO

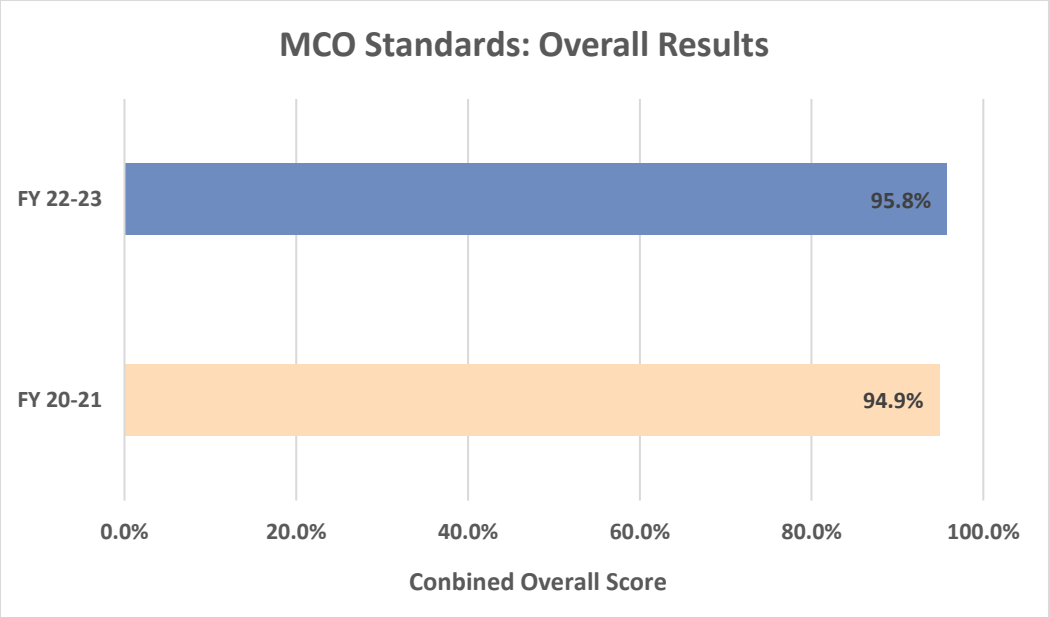
Compliance is expressed in terms of a percentage score and star rating that correlates with the *DHS Score Card*, identified in the table below. In FY 22-23, the *DHS Score Card* incorporated half-stars into the rating scale. See Appendix 2 for more information about the scoring methodology.

Scoring Legend		
Percentage Met	**Stars**	**Rating**
95.0% - 100.0%	★★★★★	Excellent
90.0% - 94.9%	★★★★½	
85.0% - 89.9%	★★★★	Very Good
80.0% - 84.5%	★★★½	
75.0% - 79.9%	★★★	Good
70.0% - 74.9%	★★½	
65.0% - 69.9%	★★	Fair
60.0% - 64.9%	★½	
55.0%-59.9%	★	Poor
< 54.9%	½	

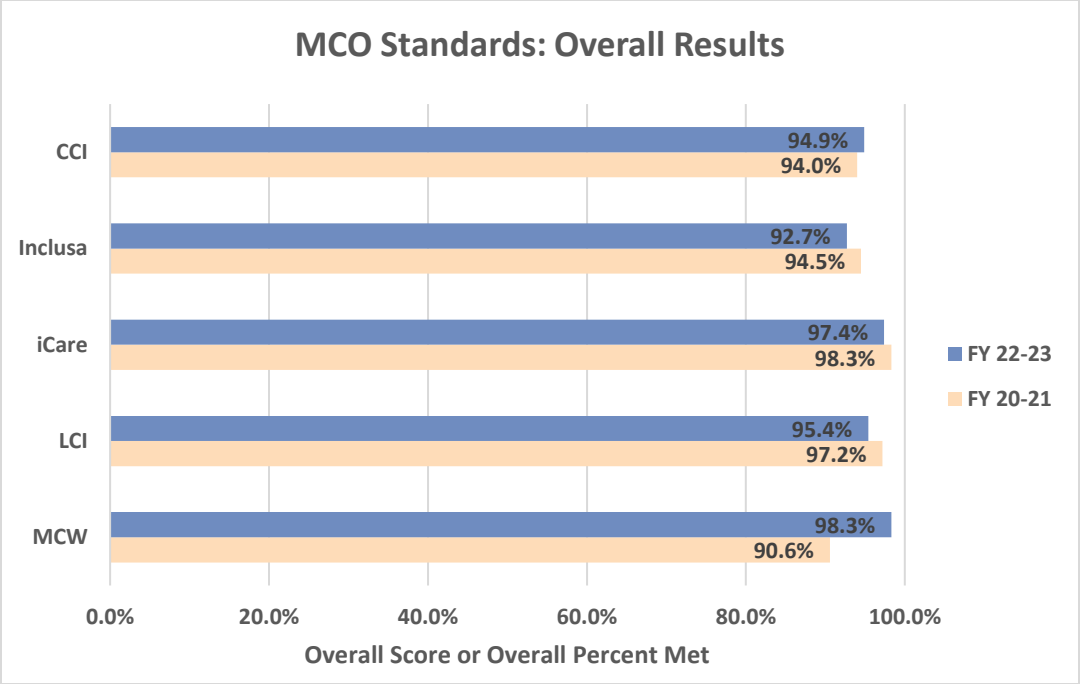
For all MCOs, the statewide compliance score is 95.8 percent, and a star rating of Excellent. The score is based on the review of the MCO Standards in FY 22-23. The table below indicates the State's overall level of compliance with all standards.

Quality Compliance Review FY 22-23				
Focus Area	**Scoring Elements**	**Percentage**	**Stars**	**Rating**
MCO Standards: Provider Network, Care Management, and Enrollee Rights	545/569	95.8%	★★★★★	Excellent
Overall	**545/569**	**95.8%**	★★★★★	**Excellent**

The graph below illustrates the State's overall compliance with these standards in FY 22-23 and compares the score to the same standards reviewed in FY 20-21.



The graph on the next page illustrates each MCOs' overall compliance with these standards in FY 22-23.



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

Results for QCR Focus Area-MCO Standards

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

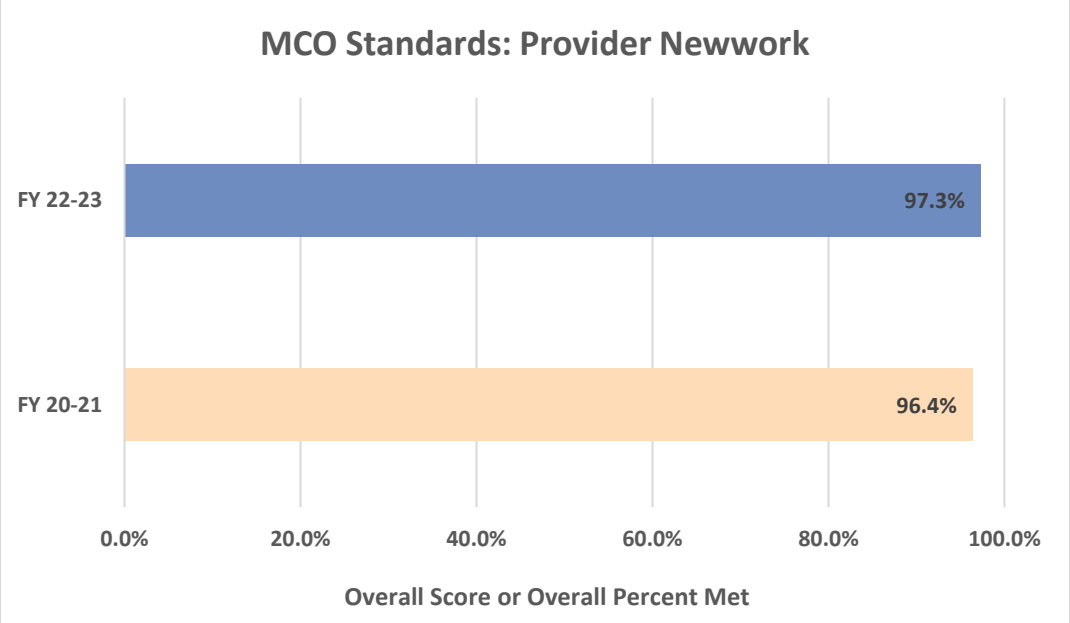
Observation and Analysis: MCO Standards, Provider Network

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

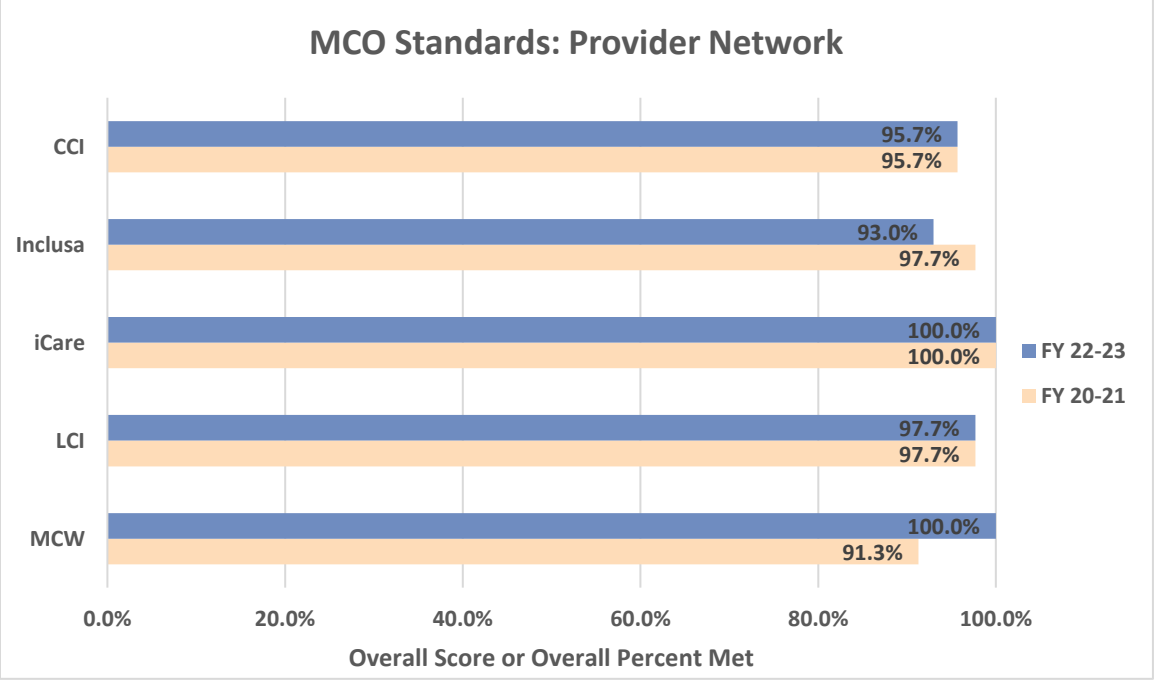
these standards, MetaStar conducted a *Provider File Verification* which entailed a sample of 90 providers from each MCO. The providers were evaluated for provider directory requirements, access and timeliness, contract compliance, and quality and performance monitoring. The outcome of the verification as used as an input to several standards and scoring elements. The table below indicates the MCOs' compliance with these standards.

MCO Standards: Provider Network				
Standard	**Scoring Elements**	**Percentage**	**Stars**	**Rating**
M1	33/34	97.1%	★★★★★	Excellent
M2	35/35	100.0%	★★★★★	Excellent
M3	20/20	100.0%	★★★★★	Excellent
M4	30/30	100.0%	★★★★★	Excellent
M13	60/65	92.3%	★★★★½	Excellent
M14	40/40	100.0%	★★★★★	Excellent
Overall	**218/224**	**97.3%**	★★★★★	**Excellent**

The graph below illustrates the State's overall compliance with this focus area in FY 22-23 and compares the score to the same focus area reviewed in FY 20-21.



The graph below illustrates each MCOs' overall compliance with this focus area in FY 22-23.



M1 Availability of services - 42 CFR 438.206

MCOs must maintain and monitor a network of appropriate providers, sufficient to provide adequate access to all services under the contract. The information is provided to members through a provider directory maintained by the MCO. The standard, M1, evaluated each MCO on eight possible scoring elements. Collectively, the MCOs satisfied requirements for 33 out of 34 scoring elements, for a score of 97.1 percent, and a star rating of Excellent.

Overall, the MCOs demonstrated compliance with this standard and ensured adequate access to all services, as well as electronic provider directories on the organization's websites. Processes for members to access services outside the provider network were confirmed for each MCO.

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

To ensure timely access to care and services, MCOs require providers to meet state standards. The MCO must monitor compliance, and take corrective action if needed. The standard, M2, evaluated each MCO on seven possible scoring elements. Collectively, the MCOs satisfied

requirements for 35 out of 35 scoring elements, for a score of 100.0 percent, and a star rating of Excellent.

All MCOs had mechanisms in place to ensure timely access to services, such as after-hours lines, regular reporting, and monitoring. The interview sessions with MCO IDT staff and the *Provider File Verification* confirmed each MCO had processes in place to ensure services are available to members twenty-four hours a day, seven days a week, as appropriate. All MCOs satisfied requirements for this standard.

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

MCOs must participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members. The standard, M3, evaluated each MCO on four possible scoring elements. Collectively, the MCOs satisfied requirements for 20 out of 20 scoring elements, for a score of 100.0 percent, and a star rating of Excellent.

All MCOs demonstrated a commitment to culturally competent service delivery to members. Compliance was evidenced through the inclusion of cultural competency expectations in policies, procedures and training for MCO staff. Additional evidence included translation of documents into different languages, coordination of interpreter services for members, incorporation of cultural preferences into assessments, utilizing technology to connect members with their culture, educational materials for providers, and community outreach. Each MCO satisfied requirements for this standard.

M4 Network adequacy - 42 CFR 438.207

MCOs must demonstrate how it maintains and monitors a network of appropriate providers, sufficient to provide adequate access to all services under the contract. The standard, M4, evaluated each MCO on six possible scoring elements. Collectively, the MCOs satisfied requirements for 30 out of 30 scoring elements, for a score of 100.0 percent, and a star rating of Excellent.

All MCOs demonstrated robust provider networks and systems in place to ensure adequate access to services. Methods and tools, such as tracking spreadsheets, for maintaining and monitoring the provider network was evidenced for long-term care services and acute and primary care services. All MCOs satisfied requirements for this standard.

M13 Provider selection - 42 CFR 438.214

MCOs must have a written process for the selection and retention of qualified providers. The MCOs are responsible for ensuring all applicable provider requirements are met at initial

contacting and throughout the duration of the contract. The standard, M13, evaluated each MCO on 13 possible scoring elements. Collectively, the MCOs satisfied requirements for 60 out of 65 scoring elements, for a score of 92.3 percent, and a star rating of Excellent.

MCOs satisfied the majority of requirements in this standard. The *Provider File Verification* indicated strong practices in place for the selection and retention of providers, including ongoing monitoring to ensure compliance.

Scoring element M13.1 requires the MCO to implement written policies and procedures for a network provider selection and retention process. All MCOs had written provider selection and retention policies and procedures. Two of five MCOs satisfied requirements for this scoring element. The *Provider File Verification* identified three MCOs that were not completing all required selection procedures prior to contracting.

M14 Subcontractual relationships and delegation - 42 CFR 438.230

MCOs must oversee and be accountable for functions and responsibilities that it delegates to any subcontractor/provider. The MCOs must monitor the subcontractor/provider's performance, and take corrective action if needed. The standard, M14, evaluated each MCO on eight possible scoring elements. Collectively, the MCOs satisfied requirements for 40 out of 40 scoring elements, for a score of 100.0 percent, and a star rating of Excellent.

All MCOs utilized a robust contract with expectations and responsibilities of providers. Some MCOs also incorporated agreements for anticipated short-term services, as well as attestations of the provider's acceptance of responsibilities and requirements. Monitoring providers for performance and quality was demonstrated by all MCOs through internal tracking mechanisms, incident management systems, and oversight committees. All MCOs satisfied requirements for this standard.

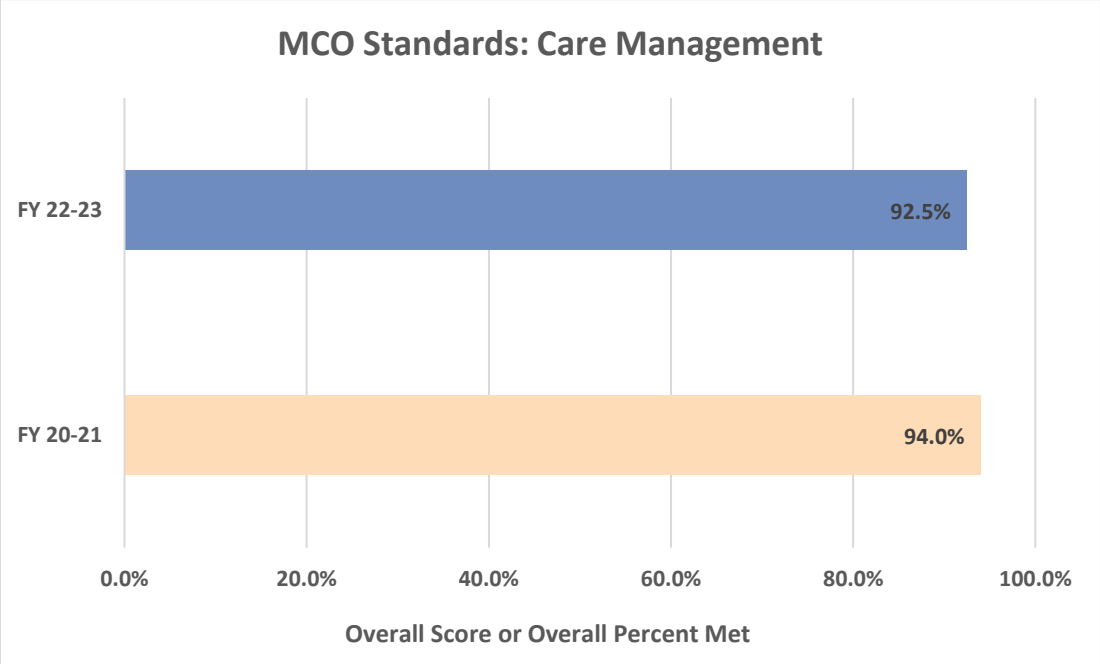
Observation and Analysis: MCO Standards, Care Management

MCOs must provide members timely access to high quality long-term care and health care services by developing and maintaining the structure, operations, and processes to ensure coordination and continuity of member care, timely authorization of services and issuance of notices to members. Five standards address requirements related to coordination and continuity of care, and coverage and authorization of services. The results of MetaStar's Care Management Review (CMR) and the MCO's internal monitoring results of care management practices are used as an input to several of the standards and scoring elements. The table below indicates the MCOs' compliance with these standards.

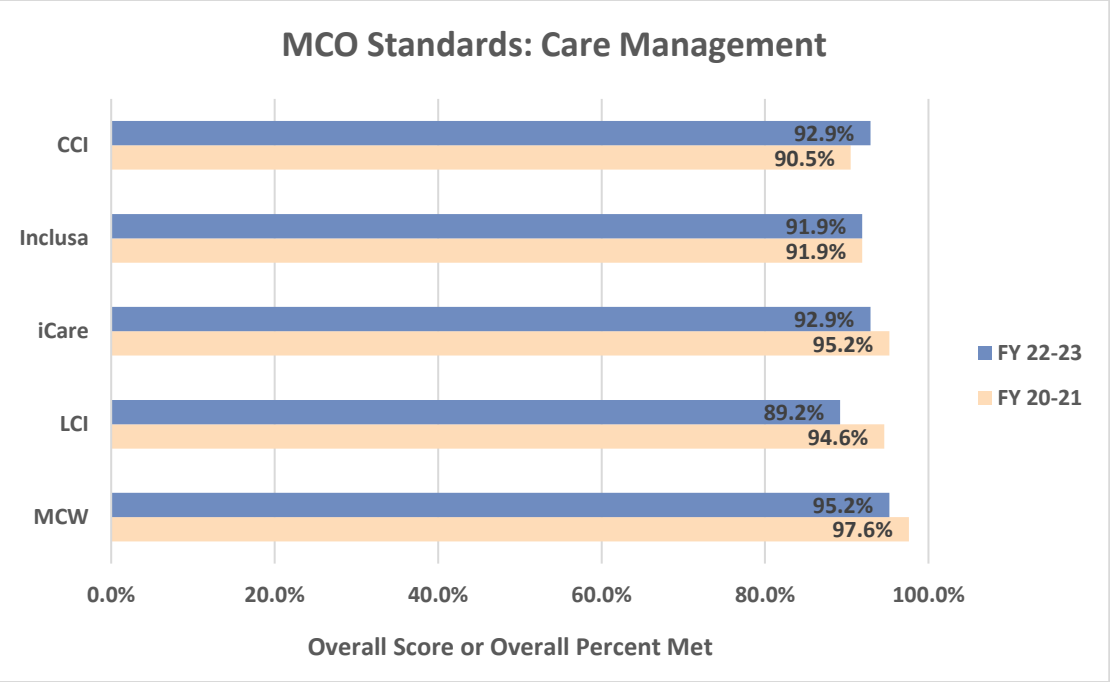
MCO Standards: Care Management				
Standard	**Scoring Elements**	**Percentage**	**Stars**	**Rating**
M5	55/60	91.7%	★★★★½	Excellent
M6	42/50	84.0%	★★★½	Very Good
M7	19/20	95.0%	★★★★★	Excellent
M8	50/50	100.0%	★★★★★	Excellent
M15	19/20	95.0%	★★★★★	Excellent
M16*	NA	NA	NA	NA
Overall	**185/200**	**92.5%**	★★★★½	**Excellent**

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

The graph below illustrates the State's overall compliance with this focus area in FY 22-23 and compares the score to the same focus area reviewed in FY 20-21.



The graph on the next page illustrates each MCOs' overall compliance with this focus area.



Overall, policies and procedures submitted by the MCOs met requirements. Training plans submitted by the MCOs demonstrated IDT staff training on requirements upon hire and annually thereafter or, as needed. Aptitude tests are used by most MCOs to demonstrate the application of training and solidify learning. Mentoring programs are a common practice, where staff are assigned to an experienced IDT staff who serves as a resource and support to the new employee. Interview sessions with IDT staff and supervisory and support staff confirmed implementation of these practices. Each MCO evidenced a number of resources that support care management practices, including guides, tip sheets, and newsletters. IDT staff from all MCOs indicated the ability to seek supervisory support and support from other departments when needed. All MCOs make use of available technologies to support care management practices, such as fields that auto-populate or auto-reminders to staff of different tasks. All MCOs had a system in place to monitor care management practices, typically through an internal file review process, which was identified as a mechanism for providing feedback on care management practices, and described as a collaborative process, focused on learning.

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

Two standards address requirements related to coordination and continuity of care. The MCOs are responsible for providing, arranging, coordinating, and monitoring services for members,

and adhering to all confidentiality requirements (M5). The standard, M5, evaluated each MCO on 12 possible scoring elements. Collectively, the MCOs satisfied requirements for 55 out of 60 scoring elements, for a score of 91.7 percent, and a star rating of Excellent.

Scoring element M5.1 require the MCOs to ensure coordination of long-term care services with health care services received by the member, as well other services available from natural and community supports. Monitoring results from the MCOs' internal file review, as well as MetaStar's care management review show a need for improvement related to follow-up for all MCOs. No MCOs satisfied requirements for scoring element M5.1.

The MCOs are responsible for ensuring member-centered planning processes are implemented and monitored (M6). The standard, M6, evaluated each MCO on 10 possible scoring elements. Collectively, the MCOs satisfied requirements for 42 out of 50 scoring elements, for a score of 84.0 percent, and a star rating of Very Good.

Scoring element M6.1 requires that the MCOs use an assessment protocol that includes a face-to-face interview in the member's current residence by the IDT care manager and registered nurse. Three MCOs satisfied requirements for this scoring element. Internal monitoring results related to comprehensive assessments for two MCOs indicated a need for additional improvement, as did the MetaStar CMR results.

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

M7 Disenrollment: requirements and limitations - 42 CFR 438.56

MCOs must comply with requirements for member disenrollment. The standard, M7, evaluated each MCO on four possible scoring elements. Collectively, the MCOs satisfied requirements for 19 out of 20 scoring elements, for a score of 95.0 percent, and a star rating of Excellent.

MCOs satisfied the requirements of this standard, as evidence through review of policies and procedures.

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

MCO policies and procedures for service authorizations must comply with required standards. The standard, M8, evaluated each MCO on 12 possible scoring elements. Collectively, the MCOs satisfied requirements for 50 out of 50 scoring elements, for a score of 100.0 percent, and a star rating of Excellent.

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

M15 Practice guidelines - 42 CFR 438.236

MCOs are required to adopt, apply, and disseminate practice guidelines based on the needs of its members (M15). The standard, M15, evaluated each MCO on four possible scoring elements. Collectively, the MCOs satisfied requirements for 19 out of 20 scoring elements, for a score of 95.0 percent, and a star rating of Excellent.

MCOs demonstrated compliance with this standard. Practice guidelines are based on member needs, reviewed routinely and available to members, staff, and providers. Interview sessions with IDT staff confirmed the practices are implemented.

M16 Health information systems – 42 CFR 438.242

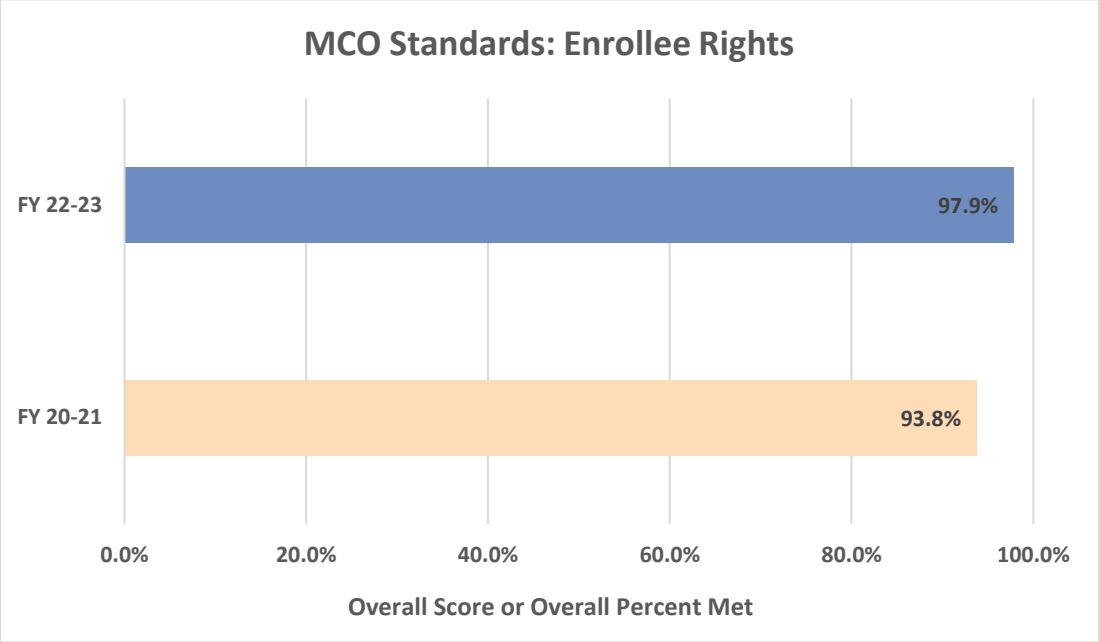
MCOs must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment, for other than loss of Medicaid eligibility. This standard is evaluated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

Observation and Analysis: MCO Standards, Enrollee Rights

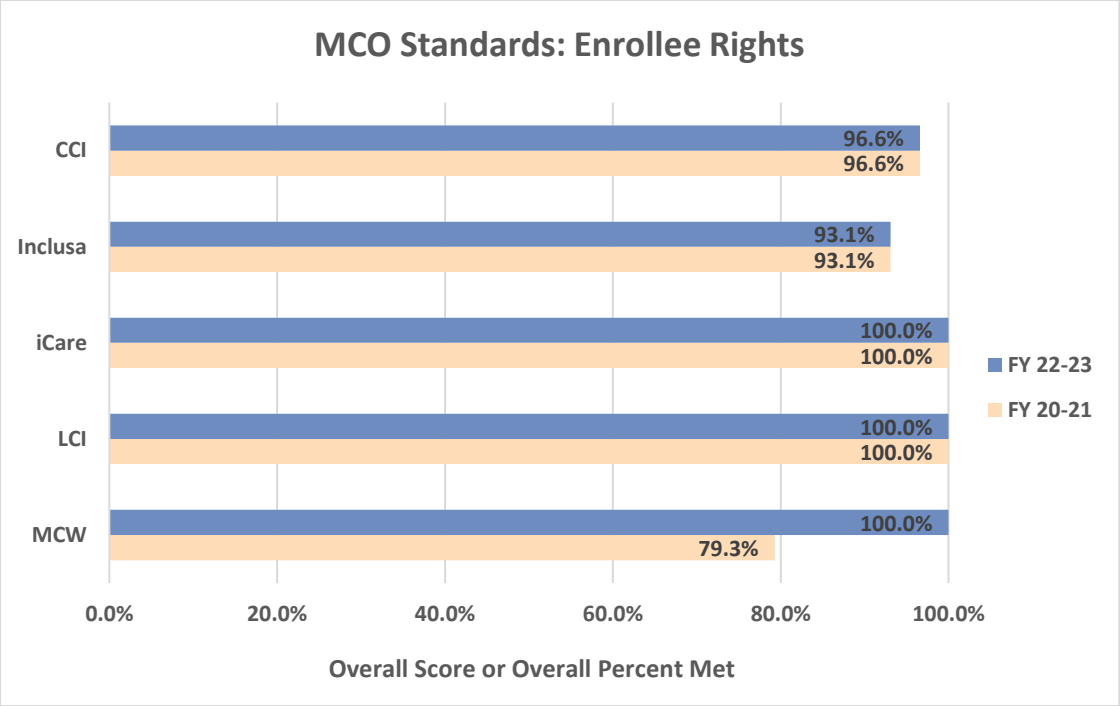
MCOs are responsible to help members understand their rights as well as to ensure those rights are protected. This requires an adequate organizational structure and sound processes that adhere to federal and state requirements and ensure that members' rights are protected. Four standards comprise this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

MCO Standards: Enrollee Rights				
Standard	**Scoring Elements**	**Percentage**	**Stars**	**Rating**
M9	59/60	98.3%	★★★★★	Excellent
M10	19/20	95.0%	★★★★★	Excellent
M11	54/55	98.2%	★★★★★	Excellent
M12	10/10	100.0%	★★★★★	Excellent
Overall	**142/145**	**97.9%**	★★★★★	**Excellent**

The graph below illustrates the State's overall compliance with this focus area in FY 22-23 and compares the score to the same focus area reviewed in FY 20-21.



The graph on the next page illustrates each MCOs' overall compliance with this focus area in FY 22-23.



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

Organizations are required to provide readily accessible written information to members in a manner and format that is easily understood. The standard, M9, evaluated each MCO on 12 possible scoring elements. Collectively, the MCOs satisfied requirements for 59 out of 60 scoring elements, for a score of 98.3 percent, and a star rating of Excellent.

The documents submitted and interviews with the MCOs' staff confirmed all organizations provide members with written materials in a manner and format that is easily understood, including alternative formats and languages when needed. In general, organizations have a consent process and safeguards in place when members request materials be provided in an electronic format. All MCOs demonstrated that required member materials are provided to new members in a timely manner upon enrollment.

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

Members must receive information on available provider options. Additionally, MCOs will not restrict a provider acting within the lawful scope of practice, or from advising or advocating on behalf of a member. The standard, M10, evaluated each MCO on four possible scoring

elements. Collectively, the MCOs satisfied requirements for 19 out of 20 scoring elements, for a score of 95.0 percent, and a star rating of Excellent.

The documents submitted and interviews with the MCOs' staff confirmed all organizations inform members of provider options upon enrollment, including the right to change providers. Overall, organizations have written guidance in place for MCO staff and providers to ensure MCOs do not prohibit or restrict a provider from acting within the lawful scope of practice, or from advising or advocating on behalf of members.

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

MCOs will have written policies and procedures for member rights and advance directives, which include the right to participate in decisions regarding his or her care, the right to refuse treatment, and be free of any form of restraint. The standard, M11, evaluated each MCO on 11 possible scoring elements. Collectively, the MCOs satisfied requirements for 54 out of 55 scoring elements, for a score of 98.2 percent, and a star rating of Excellent.

All MCOs have written policies and procedures for member rights and advance directives. All organizations' restraint policies demonstrated standard systems for restrictive measure approvals, renewals and timely submissions to the DHS. In general, the review of each MCOs' restrictive measures log confirmed these practices.

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

MCOs will have written safeguards for the protection of member rights. The language and practices of the MCO shall recognize each member as an individual and emphasize each member's capabilities. The standard, M12, evaluated each MCO on two possible scoring elements. Collectively, the MCOs satisfied requirements for 10 out of 10 scoring elements, for a score of 100.0 percent, and a star rating of Excellent.

All MCOs have written guidance for protecting of member rights that emphasized members' capabilities and respectful interactions with members. The interviews with the MCOs' staff confirmed these practices.

Conclusions

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

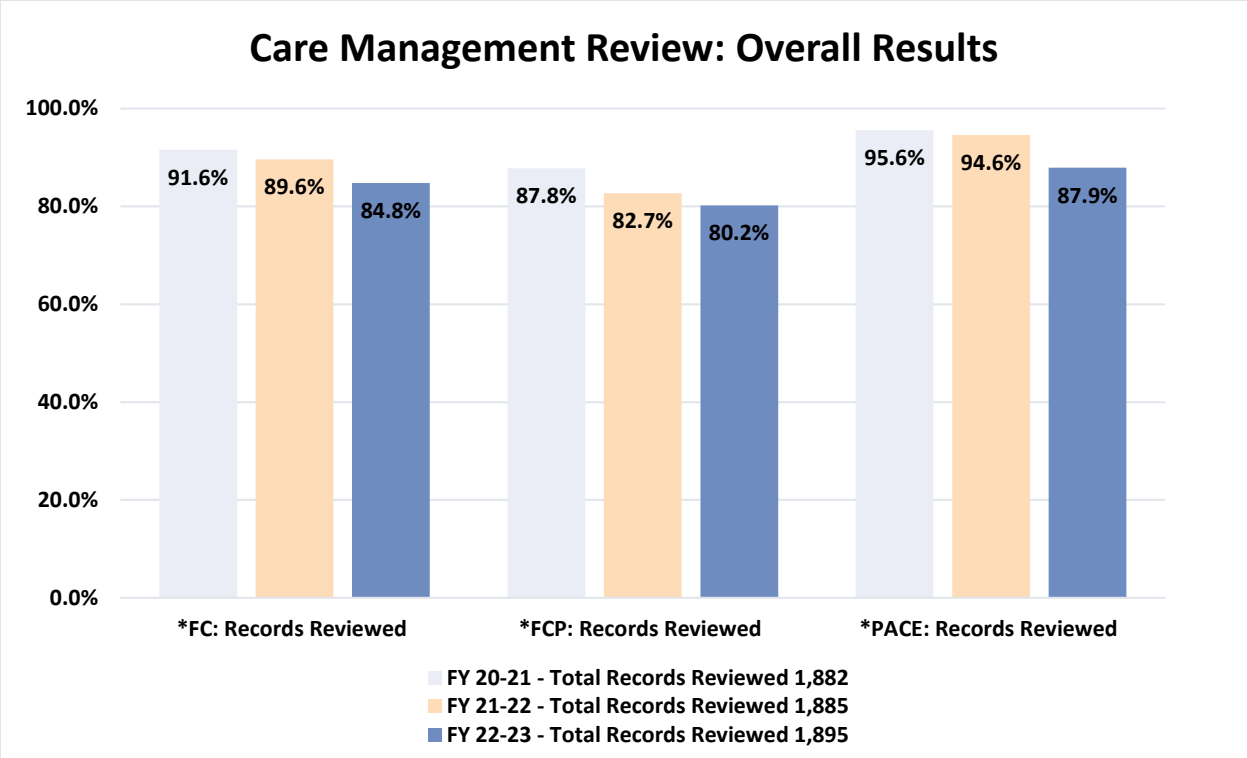
Protocol 9: Conducting Focused Studies of Health Care Quality - Care Management Review

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

The CMR was conducted using a review tool and reviewer guidelines developed by MetaStar and approved by DHS. In 2020, the State of Wisconsin was impacted by the coronavirus pandemic, a global pandemic caused by COVID-19. COVID-19 caused an outbreak of respiratory illnesses, putting many individuals at risk, especially older adults and people who have chronic medical conditions. In an effort to curb the spread of the virus, face-to-face interactions were limited, including interactions between members and MCO staff. DHS implemented a number of flexibilities to the DHS-MCO contract requirements in response to the pandemic. These flexibilities were incorporated into CMR reviewer guidance, effective March 1, 2020 – May 31, 2021 and January 1, 2022 – February 28, 2022. More information about the CMR review methodology can be found in Appendix 2.

Overall Results by Program

The bar graph on the next page represents the overall percent of CMR standards met by each program in FY 22-23 for all 15 review indicators. Four indicators were added to the review in FY 22-23, making the overall results not comparable to results from prior years. Results per indicator are still comparable and prior year's results will be included.



The overall results for each MCO and program are found in Appendix 4 of this report. CCI is the only MCO operating the PACE program; therefore, there are no MCO level comparisons for this program.

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

Results for each CMR Focus Area

Each section below provides a brief explanation of a key category of CMR, followed by a bar graph for each program (FC, FCP, and PACE) which represents the MCO's FY 22-23 results for each of the review indicators comprising the CMR category. The notes below each bar graph specify the number of applicable records when it is less than the total number reviewed.

Comprehensive Assessment

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

- Personal experience outcomes;
- Long-term care outcomes;
- Strengths;
- Preferences;
- Natural and community supports;
- Risks related to health and safety; and
- Ongoing clinical or functional conditions and needs that require long-term care, a course of treatment, or regular care monitoring.

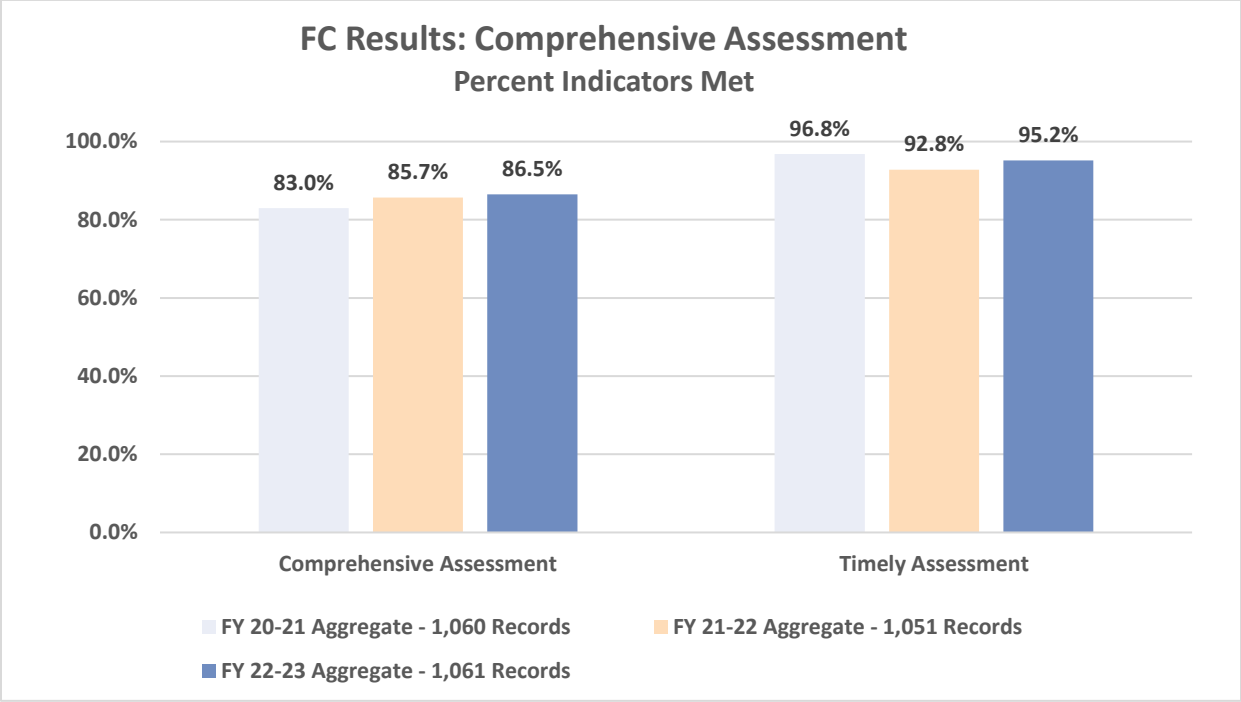
The initial assessment and subsequent reassessments must meet the timelines and other requirements described in the DHS-MCO contract.

FC

The indicator *Comprehensive Assessment* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. Of all applicable assessment elements reviewed, 99.5 percent were found to be assessed. Results for the indicator per record were similar to the prior review and reflect opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Including a detailed description of behaviors for prescribed behavior modifying medication is the primary reason for not met scores.

The indicator *Timely Assessment* evaluates if assessments were conducted every six months by both members of the IDT in accordance with the DHS-MCO contract requirements. Results for the indicator increased from the prior review and reflect strong practices. Analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance. Improvement was identified in assessments conducted in-person by both IDT staff.

Results for Comprehensive Assessment for MCOs Operating FC:

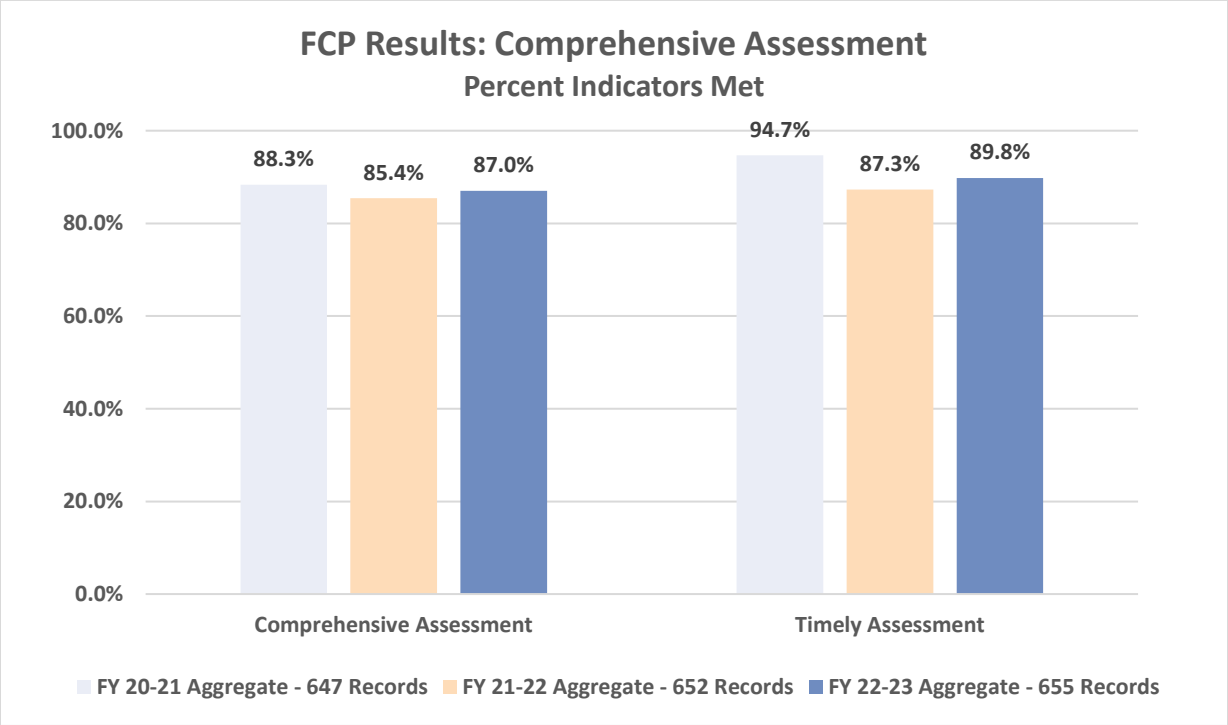


FCP

The indicator *Comprehensive Assessment* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. Of all applicable assessment elements reviewed, 99.4 percent were found to be assessed. Results for the indicator per record were similar to the prior review and reflected opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Including a detailed description of behaviors for prescribed behavior modifying medication is the primary reason for not met scores.

The indicator *Timely Assessment* evaluates if assessments were conducted every six months by both members of the IDT in accordance with the DHS-MCO contract requirements. Results for the indicator were similar to the prior review and reflected opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Completing assessments greater than six months apart was the most common reason for not met scores for this indicator.

Results for Comprehensive Assessment for MCOs Operating FCP:

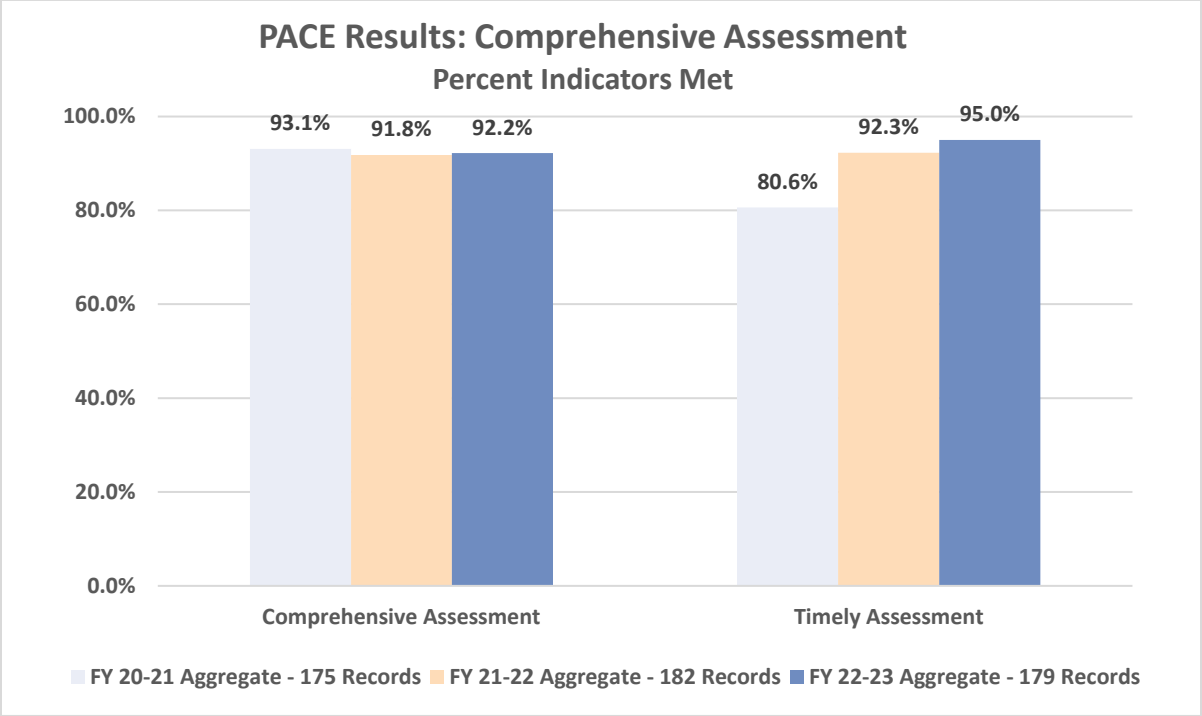


PACE

The indicator *Comprehensive Assessment* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. Of all applicable assessment elements reviewed, 99.6 percent were found to be assessed. Results for the indicator per record were similar to the prior review and reflected strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Timely Assessment* evaluates if assessments were conducted every six months by both members of the IDT in accordance with the DHS-MCO contract requirements. Results for the indicator were similar to the prior review and reflected strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

Results for Comprehensive Assessment for MCOs Operating PACE:



Member-centered Planning

The member-centered plan (MCP) and service authorization document must:

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

Additionally, the record must:

- Show that decisions regarding requests for services and decisions about member needs identified by IDT staff were made in a timely manner according to contract requirements; and
- Document that the IDT assessed and responded to members' identified risks.

FC

The indicator *Comprehensive MCP* ensures member MCPs include all assessed needs. Of all MCP elements reviewed, 96.6 percent were found to be included on the plan. Results for the indicator per record were similar to the prior review and reflected a need for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Identifying services or supports for assessed toileting needs, such as a caregiver, durable medical equipment (DME), or disposable medical supplies (DMS) is the primary reason for not met scores.

The indicator *Timely MCP* evaluates if MCPs were reviewed and signed every six months in accordance with the DHS-MCO contract requirements. Results for the indicator declined from the prior review and reflected 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 the majority of records found not met, the prior MCP was not signed, making the current MCP not timely. MCPs were found to be signed at least once annually in 96.9 percent of all records.

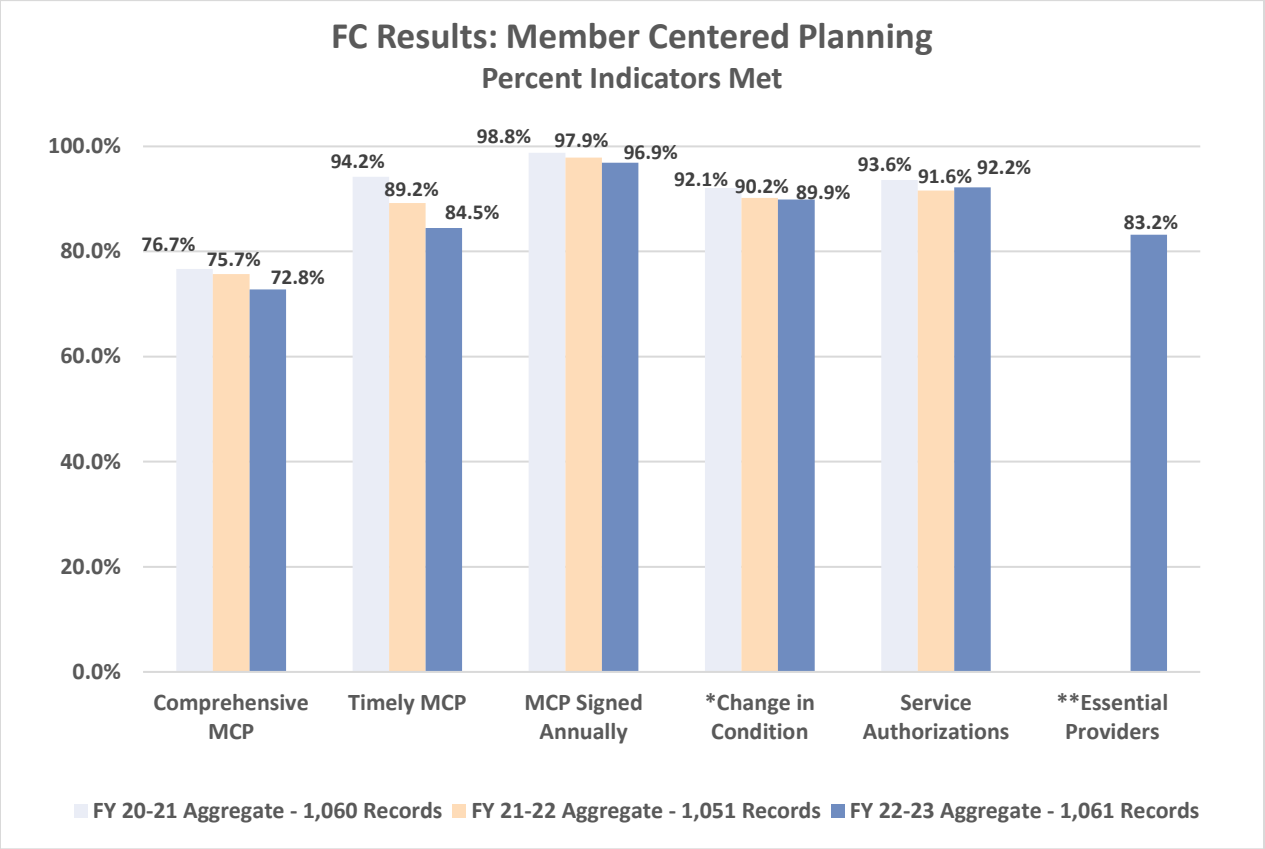
The indicator *Change in Condition* evaluates the IDTs assessing the member when changes occur and updating the MCP when applicable, which includes the exploration or education on risk interventions. Results for the indicator were similar to the prior review and reflected strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Service Authorizations* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests and issuing *Notice of Adverse Benefit Determination* letters when applicable. Results for the indicator were similar to the prior review and reflected opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Overall, service authorizations were handled appropriately. In several cases, *Notice of Adverse Benefit Determination* letters were indicated but not issued, often related to the IDT not making a decision on a member's request. In all records reviewed, 269 *Notice of Adverse Benefit Determination* letters were indicated, with 149 being issued timely, for an issuance rate of 55.4 percent.

The indicator *Essential Providers* evaluates the requirement to obtain signatures on the member's MCP from all essential waiver service providers. The signature on the MCP indicates that the provider has been distributed a copy of the MCP and understands their role in supporting the member. This is a newly evaluated requirement in FY 22-23 and there are no results from previous years to compare to in this review. The results indicated opportunities for

improvement. Records found not met often did not include signatures from supportive home care (SHC) providers.

Results for Member Centered Planning for MCOs Operating FC:



*Note: The review indicator *Change in Condition* applied to 318 of 1,060 records in FY 20-21, 387 of 1,051 records in FY 21-22, and 375 of 1,061 records in FY 22-23.
**Note: The review indicator *Essential Providers* applied to 817 of 1,061 records in FY 22-23. This is a newly evaluated requirement in FY 22-23 and there are no results from previous years to compare to this review.

FCP

The indicator *Comprehensive MCP* ensures member MCPs include all assessed needs. Of all MCP elements reviewed, 97.9 percent were found to be included on the plan. Results for the indicator per record increased from the prior review, though opportunities for improvement are indicated. Analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance. Identifying services or supports for assessed toileting needs, such as a caregiver, DME, or DMS is the primary reason for not met scores.

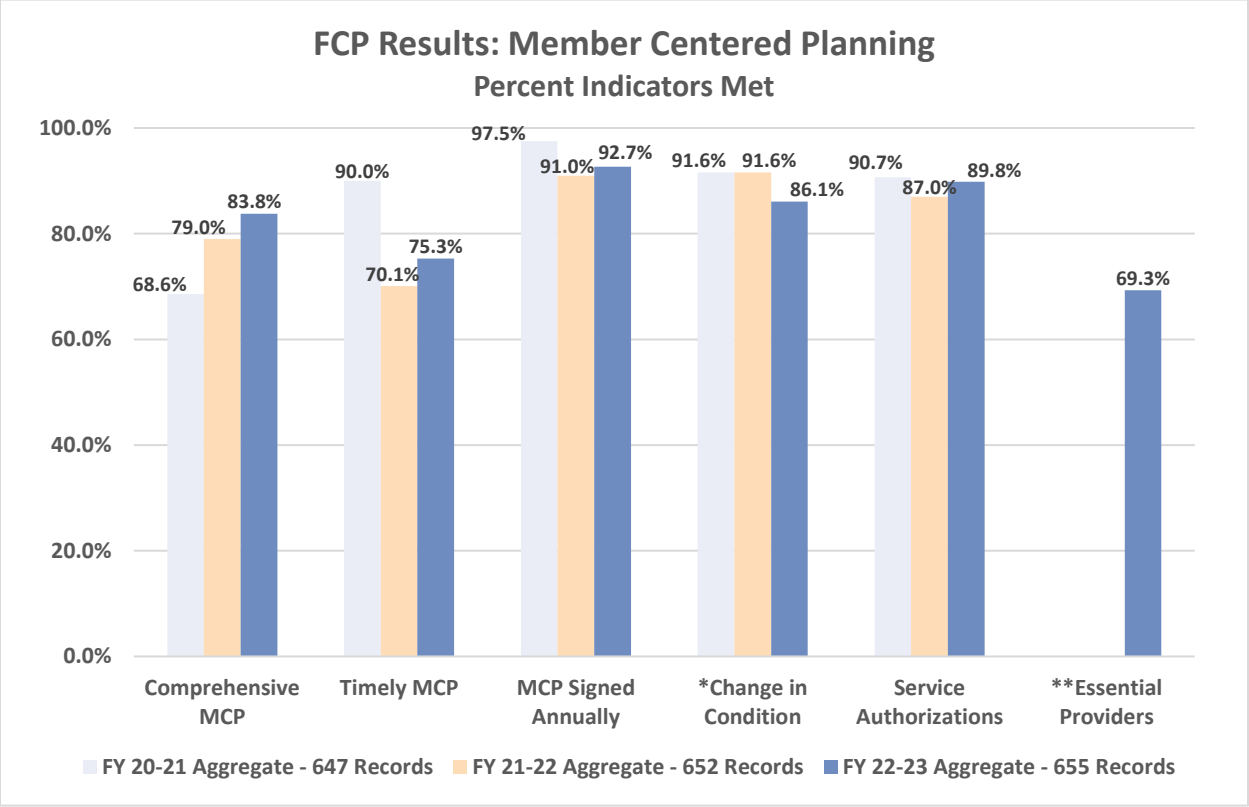
The indicator *Timely MCP* evaluates if MCPs were reviewed and signed every six months in accordance with the DHS-MCO contract requirements. Results for the indicator increased from the prior review, though opportunities for improvement are indicated. Analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance. In the majority of records found not met, the prior MCP was not signed, making the current MCP not timely. MCPs were found to be signed at least once annually in 92.7 percent of all records.

The indicator *Change in Condition* evaluates the IDTs assessing the member when changes occur and updating the MCP when applicable, which includes the exploration or education on risk interventions. Results for the indicator declined from the prior review and reflected 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 the majority of records found not met, the member's MCP was not updated following a move to a skilled nursing facility, or other change in residential placement.

The indicator *Service Authorizations* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests and issuing *Notice of Adverse Benefit Determination* letters when applicable. 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. Records found not met were related to issuing notices as required. Overall, service authorizations were handled appropriately. In several cases, *Notice of Adverse Benefit Determination* letters were indicated but not issued, often related to the IDT not making a decision on a member's request. In all records reviewed, 167 *Notice of Adverse Benefit Determination* letters were indicated, with 74 being issued timely, for an issuance rate of 44.3 percent.

The indicator *Essential Providers* evaluates the requirement to obtain signatures on the member's MCP from all essential waiver service providers. The signature on the MCP indicates that the provider has been distributed a copy of the MCP and understands their role in supporting the member. This is a newly evaluated requirement in FY 22-23 and there are no results from previous years to compare to in this review. The results indicated opportunities for improvement. Records found not met often did not include signatures from supportive home care (SHC) providers.

Results for Member Centered Planning for MCOs Operating FCP:



*Note: The review indicator *Change in Condition* applied to 238 of 647 records in FY 20-21, 320 of 652 records in FY 21-22, and 238 of 655 records in FY 22-23.
**Note: The review indicator *Essential Providers* applied to 492 of 655 records in FY 22-23. This is a newly evaluated requirement in FY 22-23 and there are no results from previous years to compare to this review.

PACE

The indicator *Comprehensive MCP* ensures member MCPs include all assessed needs. Of all MCP elements reviewed, 99.2 percent were found to be included on the plan. Results for the indicator per record 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 indicator *Timely MCP* evaluates if MCPs were reviewed and signed every six months in accordance with the DHS-MCO contract requirements. Results for the indicator declined from the prior review and reflected 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.

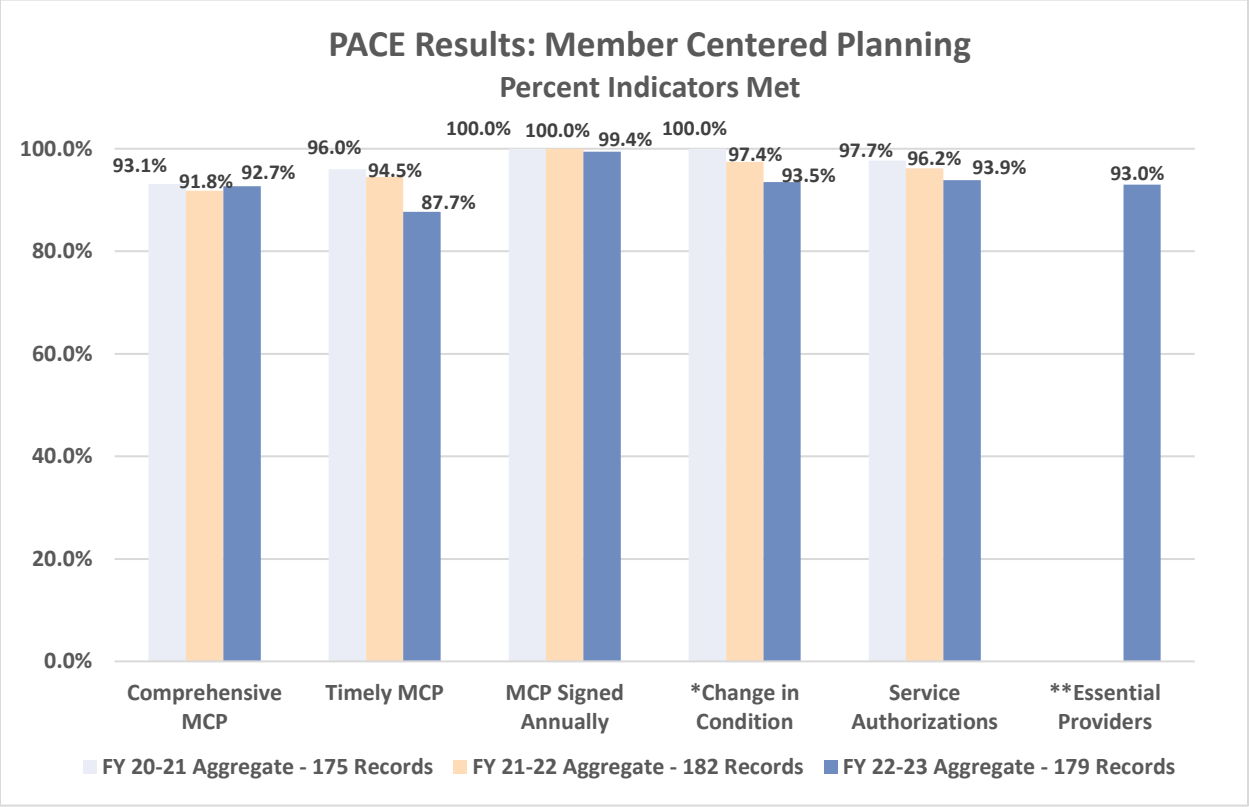
In records found not met, MCPs were reviewed, but not signed within the required timeframe. MCPs were found to be signed at least once annually in 99.4 percent of all records.

The indicator *Change in Condition* evaluates the IDTs assessing the member when changes occur and updating the MCP when applicable, which includes the exploration or education on risk interventions. 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 indicator *Service Authorizations* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests and issuing *Notice of Adverse Benefit Determination* letters when applicable. 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. Overall, service authorizations were handled appropriately. In several cases, *Notice of Adverse Benefit Determination* letters were indicated but not issued, often related to the IDT not making a decision on a member's request. In all records reviewed, 44 *Notice of Adverse Benefit Determination* letters were indicated, with 31 being issued timely, for an issuance rate of 70.5 percent.

The indicator *Essential Providers* evaluates the requirement to obtain signatures on the member's MCP from all essential waiver service providers. The signature on the MCP indicates that the provider has been distributed a copy of the MCP and understands their role in supporting the member. This is a newly evaluated requirement in FY 22-23 and there are no results from previous years to compare to in this review. Results indicated strong practices related to essential provider requirements.

Results for Member Centered Planning for MCOs Operating PACE:



*Note: The review indicator *Change in Condition* applied to 76 of 175 records in FY 20-21, 77 of 182 records in FY 21-22, and 92 of 179 records in FY 22-23.
**Note: The review indicator *Essential Providers* applied to 142 of 179 records in FY 22-23. This is a newly evaluated requirement in FY 22-23 and there are no results from previous years to compare to this review.

Care Coordination

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

- The IDT staff coordinated the member's services and supports in a reasonable amount of time;
- The IDT staff followed up with the member in a timely manner to confirm the services/ supports were received and were effective for the member; and
- All of the member's identified needs have been adequately addressed.

FC

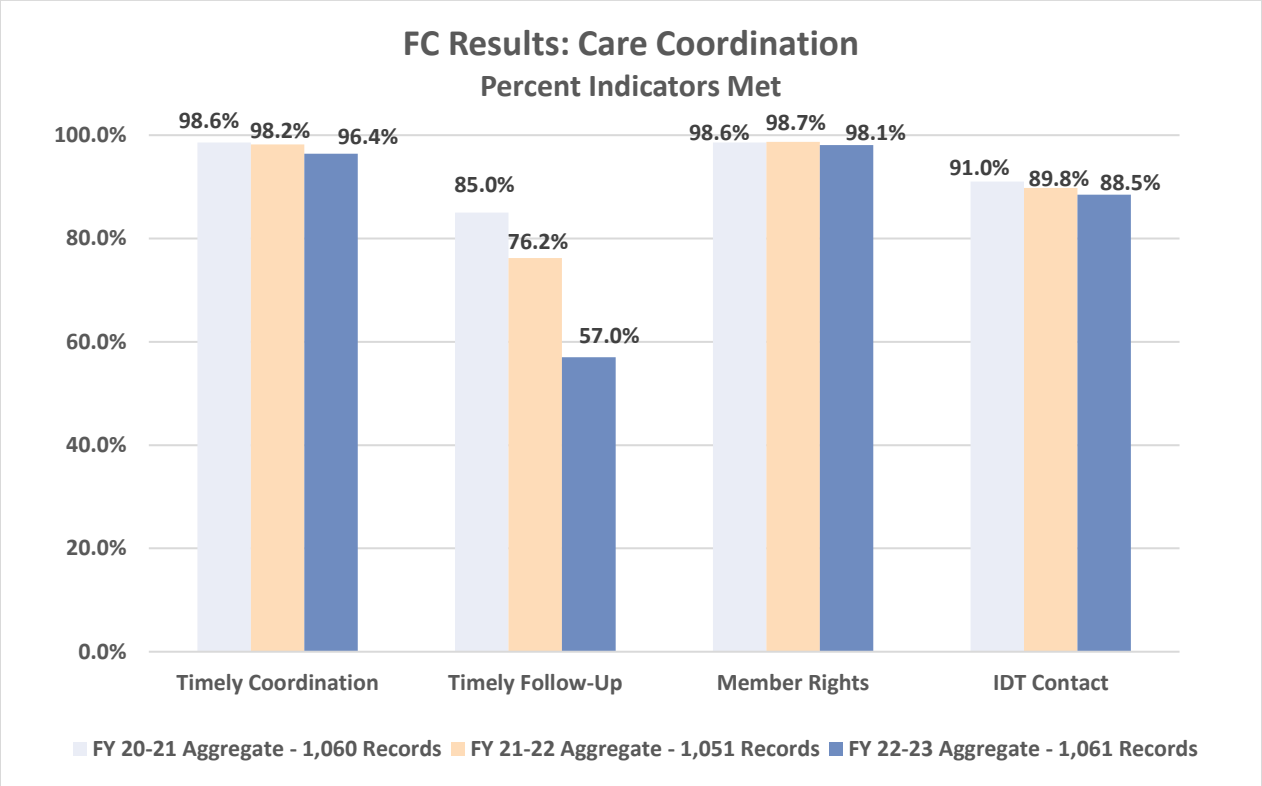
The indicator, *Timely Coordination* evaluates plans put in place by the IDT to ensure member needs and supports are coordinated timely and effectively. Results for the indicator declined from the prior review, though scores still reflected strong practices. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. The decline in results was often related to the coordination of DMS for members.

The indicator *Timely Follow-Up* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Results for the indicator declined from the prior review and reflected 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. Records found not met often did not evidence follow-up related to medical appointments, specifically dental appointments for tooth pain and dentures.

The indicator *Member Rights* evaluates the protection of member rights, such as IDT staff including the member and his/her supports in care management processes; offering and explaining the self-directed supports (SDS) option to the member; and following applicable guidelines for restrictive measures and rights limitations. 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 indicator, *IDT Contact* evaluates IDT contact requirements including monthly collateral contacts, in-person contact every three months with the member, and an annual home visit with the member by the care manager and registered nurse care manager Results for the indicator were similar to the prior review and indicated an opportunity for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Records found not met often did evidence an in-person visit with the member every three months, or a monthly collateral contact during months an in-person visit did not occur.

Results for Care Coordination for MCOs Operating FC:



FCP

The indicator, *Timely Coordination* evaluates plans put in place by the IDT to ensure member needs and supports are coordinated timely and effectively. 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.

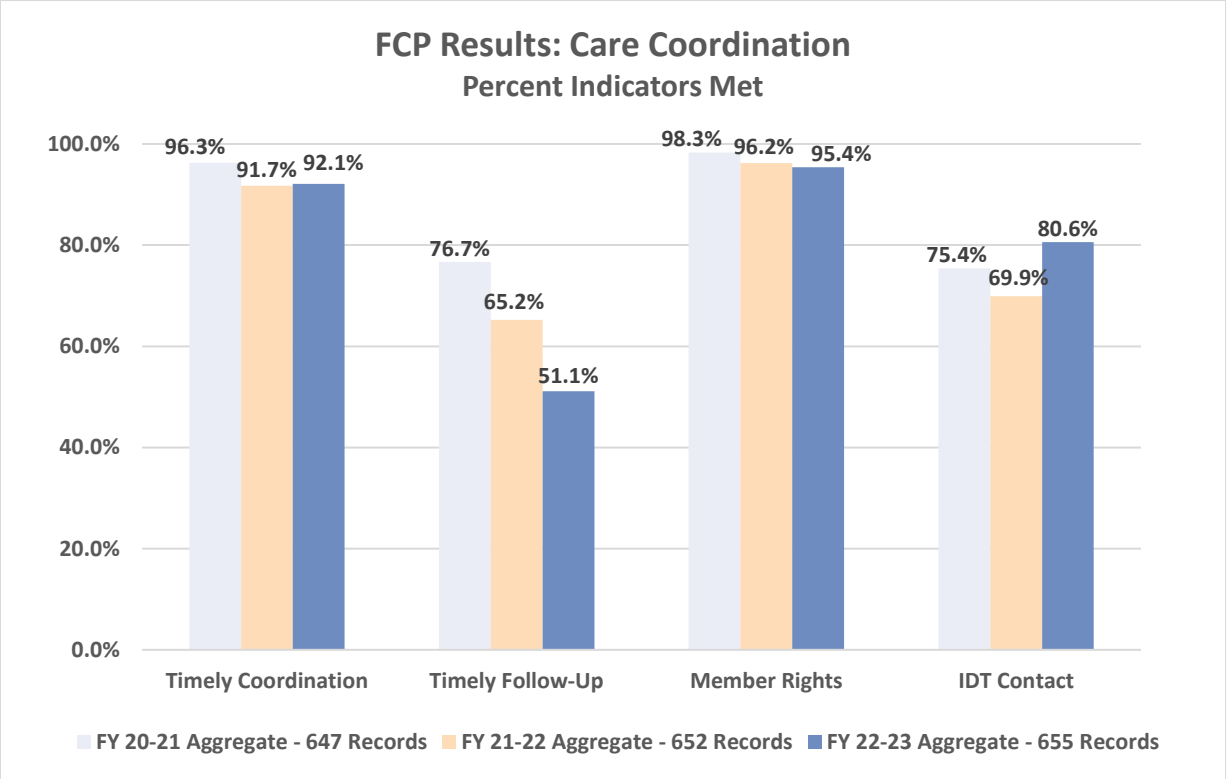
The indicator *Timely Follow-Up* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Results for the indicator declined from the prior review and reflected a need for improvement. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. Records found not met often did not evidence follow-up related to medical appointments, specifically dental appointments for tooth pain and dentures.

The indicator *Member Rights* evaluates the protection of member rights, such as IDT staff including the member and his/her supports in care management processes; offering and explaining the SDS option to the member; and following applicable guidelines for restrictive

measures and rights limitations. 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 indicator, *IDT Contact* evaluates IDT contact requirements including monthly collateral contacts, in-person contact every three months with the member, and an annual home visit with the member by the care manager and registered nurse care manager Results for the indicator increased from the prior review, though opportunities for improvement are indicated. Analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCO, and is unlikely to be the result of normal variation or chance. Records found not met often did evidence an in-person visit with the member every three months, or a monthly collateral contact during months an in-person visit did not occur.

Results for Care Coordination for MCOs Operating FCP:



PACE

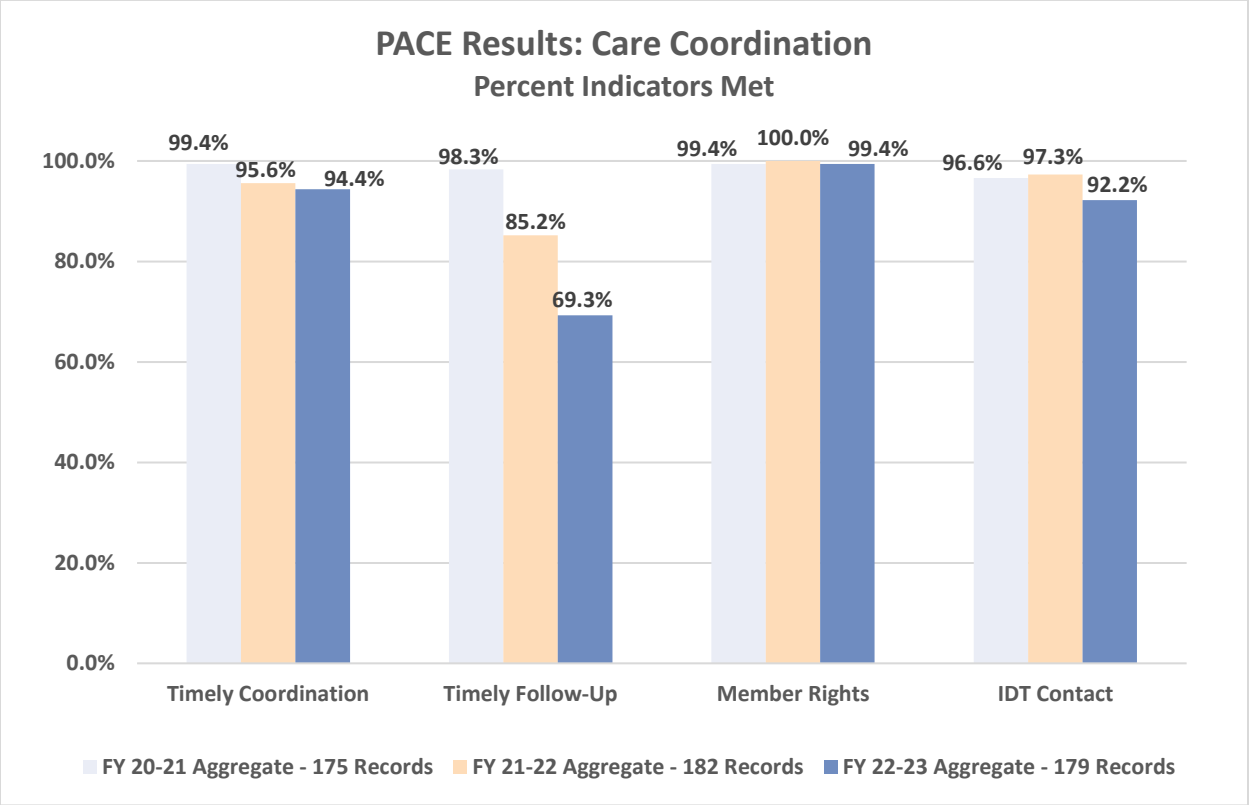
The indicator, *Timely Coordination* evaluates plans put in place by the IDT to ensure member needs and supports are coordinated timely and effectively. Results for the indicator were similar to the prior review and indicated strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The indicator *Timely Follow-Up* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Results for the indicator declined from the prior review and reflected 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. Records found not met often did not evidence follow-up related to medical appointments, specifically dental appointments for tooth pain and dentures.

The indicator *Member Rights* evaluates the protection of member rights, such as IDT staff including the member and his/her supports in care management processes; offering and explaining the SDS option to the member; and following applicable guidelines for restrictive measures and rights limitations. 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 indicator, *IDT Contact* evaluates IDT contact requirements including monthly collateral contacts, in-person contact every three months with the member, and an annual home visit with the member by the care manager and registered nurse care manager Results for the indicator declined from the prior review, though strong practices are still indicated related to contact requirements. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. Evidence of monthly collateral contacts occurring each month that an in-person visit did not occur was the most common reason for the decline in the results.

Results for Care Coordination for MCOs Operating PACE:



Long-Term Care Functional Screen

The *Wisconsin Adult Long Term Care Functional Screen* (LTCFS) is the screening tool utilized to determine an adult's nursing home level of care, intellectual/developmental disability level of care, and functional eligibility level for Wisconsin's long-term care programs. The LTCFS assesses member needs with the following activities and conditions:

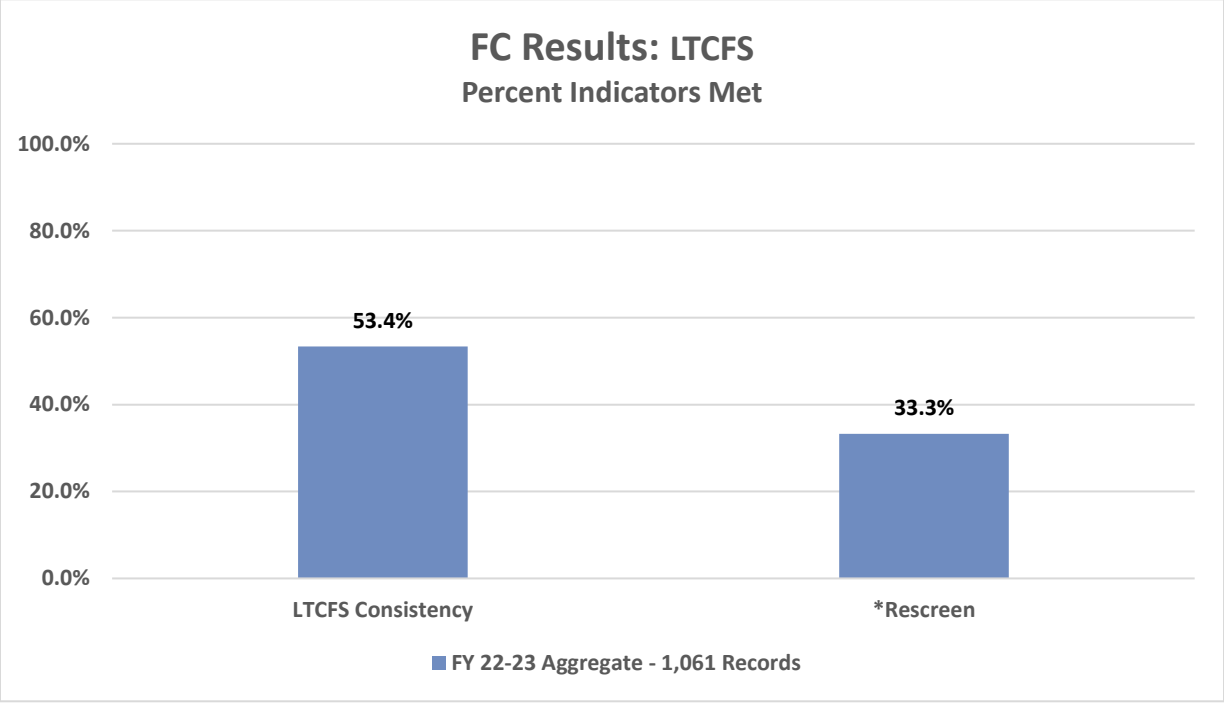
- Diagnosis;
- Activities of Daily Living (ADLs);
- Instrumental Activities of Daily Living (IADLs);
- Additional Supports;
- Health-Related Services (HRS);
- Communication and Cognition;
- Behavioral Health; and
- Risk.

FC

The indicator *LTCFS Consistency* evaluates the consistency between documentation on the member's LTCFS and the member's record (assessment or MCP). This is a newly evaluated requirement in FY 22-23 and there are no results to compare to in this review. Of all LTCFS elements reviewed, 94.8 percent were found to be consistent with MCO documentation. Results for the indicator per record demonstrated opportunities for improvement. DME for toileting is the most common area of inconsistency. Additional inconsistencies were identified in the *Health Related Task* (HRS) table, specifically for exercise and range of motion (ROM), and oxygen and respiratory treatments.

The indicator *Rescreen* evaluates if the MCO completed a rescreen when needed for a change in a member's needs. This is a newly evaluated requirement in FY 22-23 and there are no results to compare to in this review. Results indicated an opportunity for improvement. In records found not met, MCOs did not rescreen following a significant change in the member's condition.

Results for Long-Term Care Functional Screen for MCOs Operating FC:



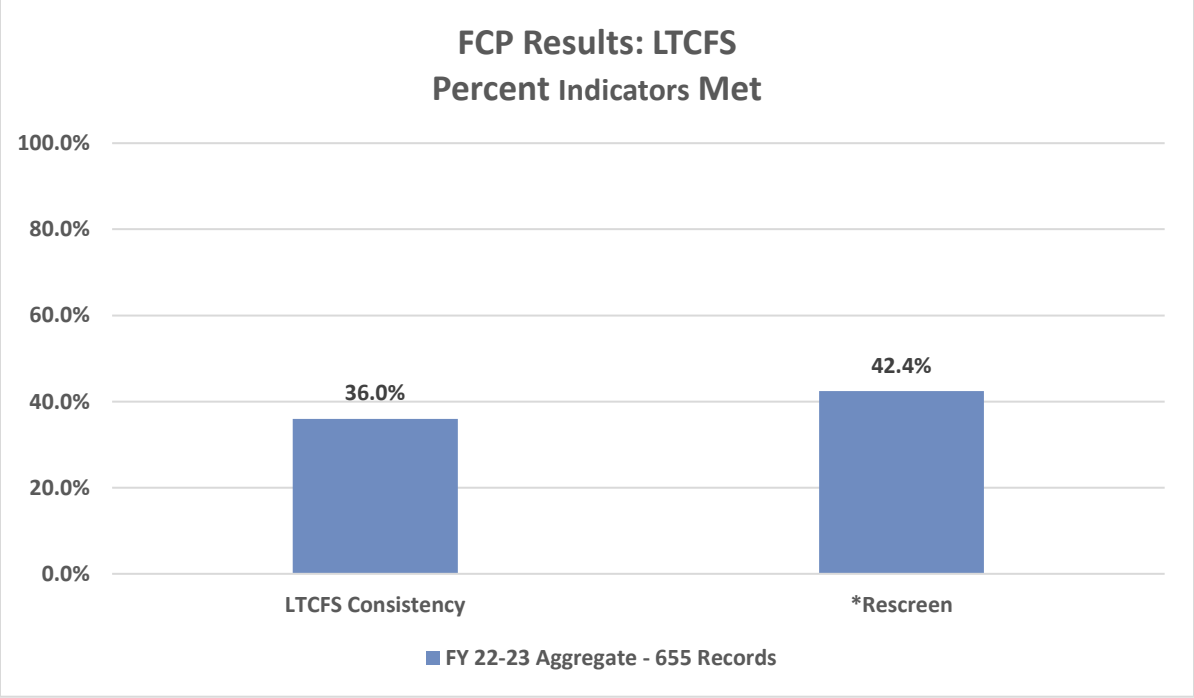
*Note: The review indicator *Rescreen* applied to 99 of 1,061 records in FY 22-23. This is a newly evaluated requirement in FY 22-23 and there are no results from previous years to compare to this review.

FCP

The indicator *LTCFS Consistency* evaluates the consistency between documentation on the member's LTCFS and the member's record (assessment or MCP). This is a newly evaluated requirement in FY 22-23 and there are no results to compare to in this review. Of all LTCFS elements reviewed, 90.5 percent were found to be consistent with MCO documentation. Results for the indicator per record demonstrated opportunities for improvement. DME for toileting is the most common area of inconsistency. Additional inconsistencies were identified in the *Health Related Task* (HRS) table, specifically for exercise and ROM, and oxygen and respiratory treatments.

The indicator *Rescreen* evaluates if the MCO completed a rescreen when needed for a change in a member's needs. This is a newly evaluated requirement in FY 22-23 and there are no results to compare to in this review. Results indicated an opportunity for improvement. In records found not met, MCOs did not rescreen following a significant change in the member's condition.

Results for Long-Term Care Functional Screen for MCOs Operating FCP:



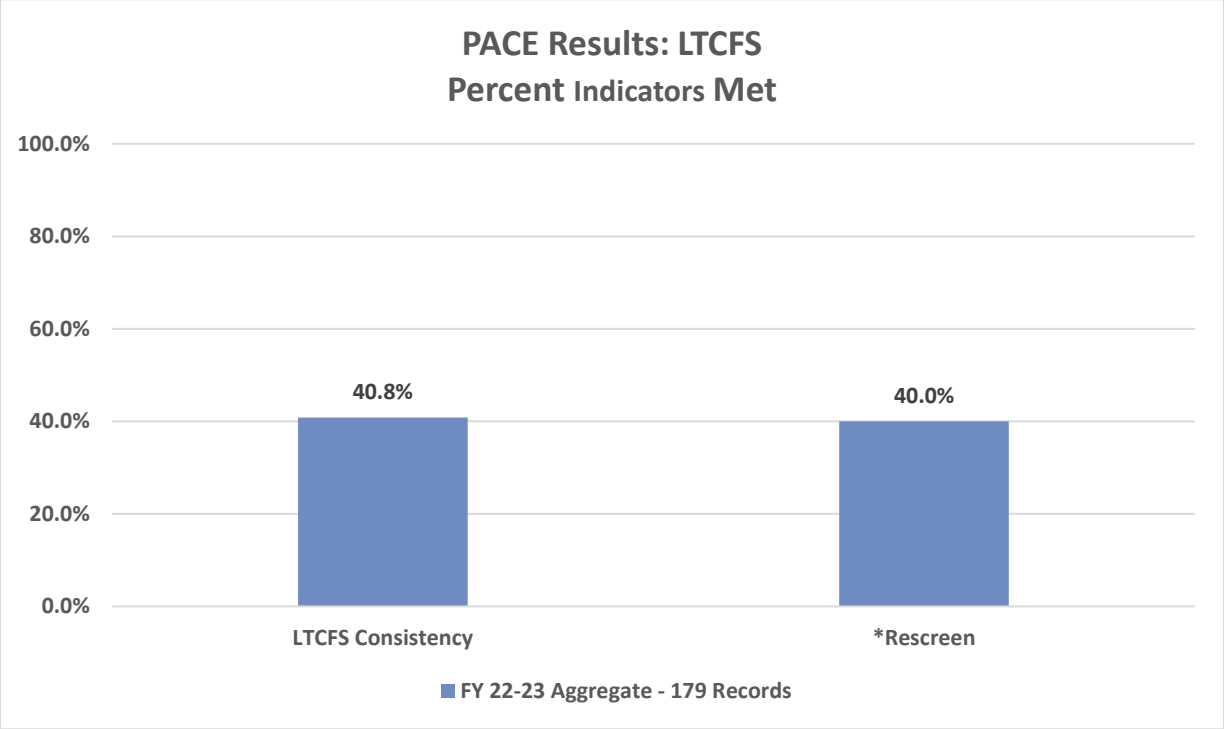
*Note: The review indicator *Rescreen* applied to 59 of 655 records in FY 22-23. This is a newly evaluated requirement in FY 22-23 and there are no results from previous years to compare to this review.

PACE

The indicator *LTCFS Consistency* evaluates the consistency between documentation on the member's LTCFS and the member's record (assessment or MCP). This is a newly evaluated requirement in FY 22-23 and there are no results to compare to in this review. Of all LTCFS elements reviewed, 93.1 percent were found to be consistent with MCO documentation. Results for the indicator per record Results for the indicator per record demonstrated opportunities for improvement. DME for toileting is the most common area of inconsistency. Additional inconsistencies were identified in the *Health Related Task* (HRS) table, specifically for exercise and ROM, and oxygen and respiratory treatments.

The indicator *Rescreen* evaluates if the MCO completed a rescreen when needed for a change in a member's needs. This is a newly evaluated requirement in FY 22-23 and there are no results to compare to in this review. Results indicated an opportunity for improvement. In records found not met, MCOs did not rescreen following a significant change in the member's condition.

Results for Long-Term Care Functional Screen for MCOs Operating PACE:



*Note: The review indicator *Rescreen* applied to 30 of 179 records in FY 22-23. This is a newly evaluated requirement in FY 22-23 and there are no results from previous years to compare to this review.

Quality of Care

The MCO is responsible for assuring all health, safety, and welfare needs of the members are supported. This includes addressing member risks and safety concerns, and the protection of member rights, including the assurance that members are not using personal resources for services in the benefit package without proper counseling from the MCO.

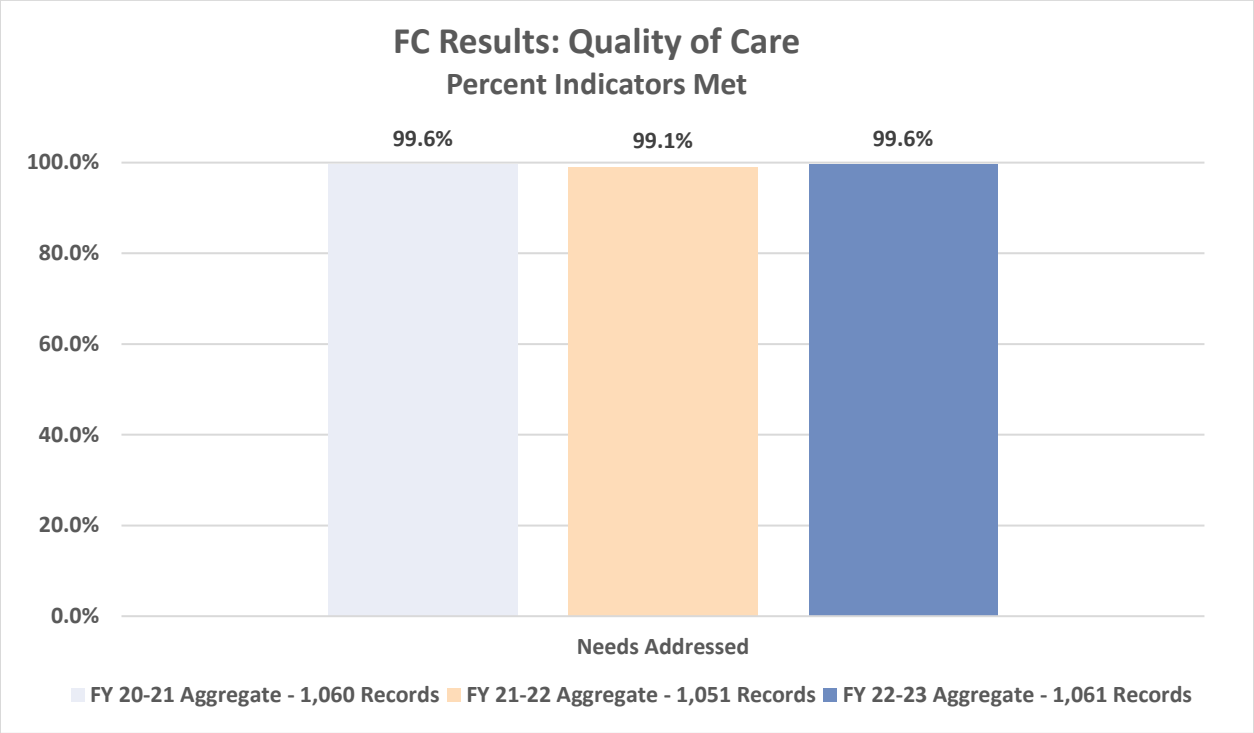
FC

The indicator *Needs Addressed* evaluates the MCO's responsibility to assure all health, safety and welfare needs of the member are adequately supported. No members with health and safety issues or complex or challenging situation were discovered in the random sample of records reviewed. Four FC members were referred to DHS for use of personal resources without evidence of counseling.

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

Results for the indicator were similar to the prior review and reflected strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

Results for Quality of Care for MCOs Operating FC:



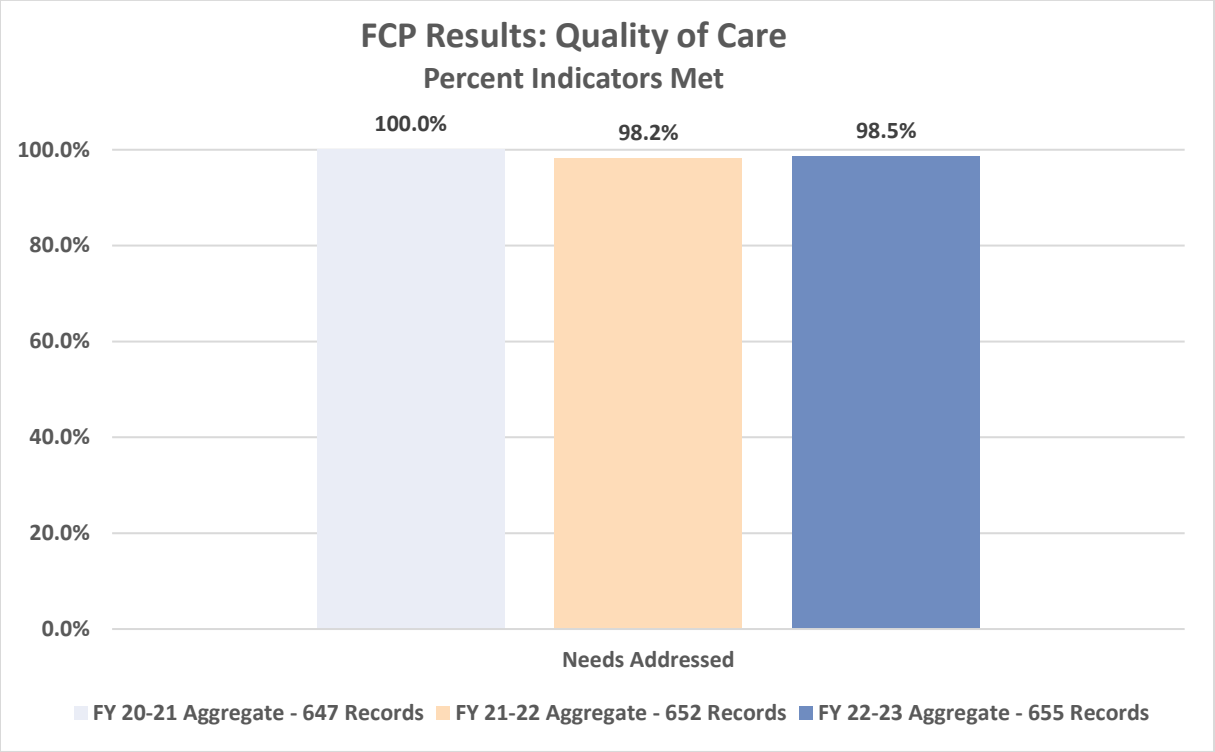
FCP

The indicator *Needs Addressed* evaluates the MCO's responsibility to assure all health, safety and welfare needs of the member are adequately supported. No members with health and safety issues were discovered in the random sample of records reviewed. One member with a complex or challenging situation was referred to DHS for additional oversight, assistance, and monitoring. Nine FCP members were referred to DHS for use of personal resources without evidence of counseling.

DHS directed MetaStar to re-review the records of members with health and safety issues and/or complex and challenging situations identified in last year's review. No FCP members were referred to DHS in the prior year for these reasons.

Results for the indicator were similar to the prior review and reflected strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

Results for Quality of Care for MCOs Operating FCP:



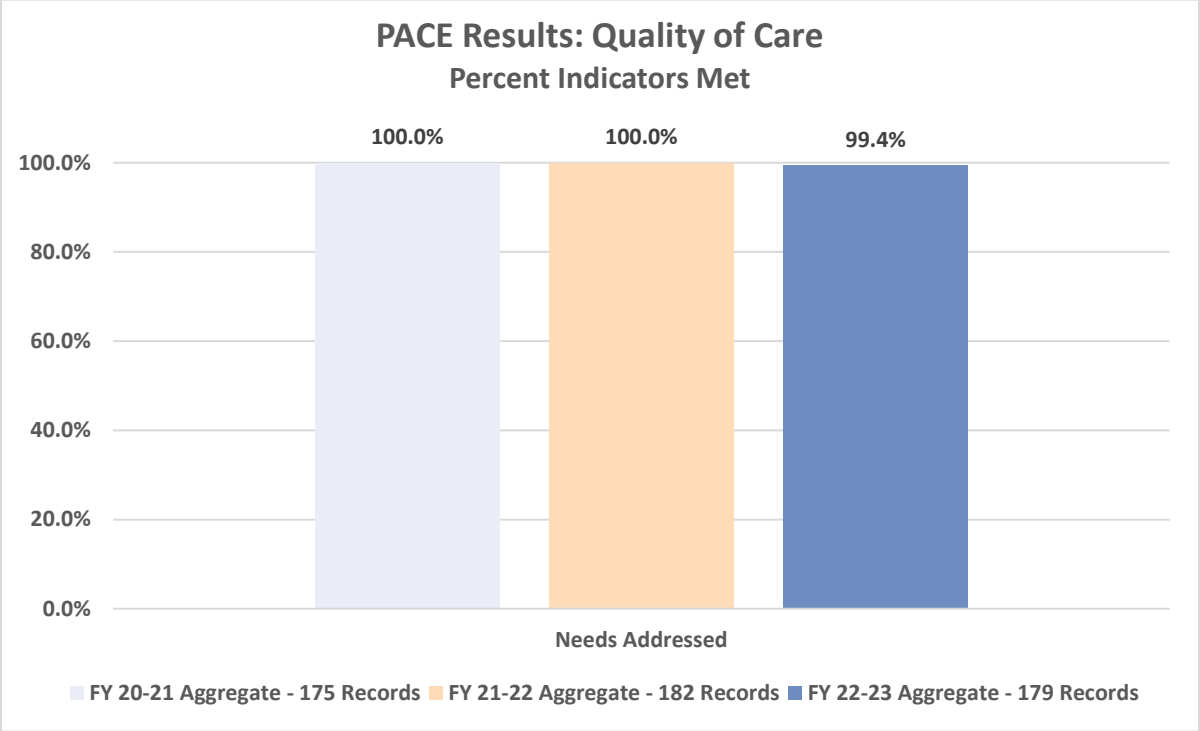
PACE

The indicator *Needs Addressed* evaluates the MCO's responsibility to assure all health, safety and welfare needs of the member are adequately supported. No members with health and safety issues or complex or challenging situation were discovered in the random sample of records reviewed. One PACE member was referred to DHS for use of personal resources without evidence of counseling.

DHS directed MetaStar to re-review the records of members with health and safety issues and/or complex and challenging situations identified in last year's review. No PACE members were referred to DHS in the prior year for these reasons.

Results for the indicator were similar to the prior review and reflected strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

Results for Quality of Care for MCOs Operating PACE:



Analysis

Aggregate results for all programs was 83.5 percent, indicating opportunities for improvement. Aggregate results for individual programs ranged from 80.2 percent to 87.9 percent. In addition to analyzing results by MCO and program, MetaStar reported data by GSR. Results identified which regions in the state were below the statewide rates. This analysis allows the state to identify potential trends in compliance based on location. Further analysis regarding geographic barriers may be warranted, such as MCO staffing patterns and provider network issues. Lastly, a review of member health and safety indicators demonstrate that MCOs are providing the necessary supports to assure member needs are being met.

Statewide Analysis

FC

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

- The results for five GSRs are below the statewide rate for *Comprehensive MCP* (72.8 percent): GSRs 6, 8, 9, 11, and 13.
- The results for five GSRs are below the statewide rate for *Timely MCP* (84.5 percent): GSRs 3, 4, 8, 11, and 12.
- The results for nine GSRs are below the statewide rate for *Essential Providers* (83.2 percent): GSRs 1, 2, 3, 4, 8, 10, 11, 12, and 14.
- The results for seven GSRs are below the statewide rate for *Timely Follow-Up* (57.0 percent): GSRs 1, 2, 4, 5, 10, 11, and 12.
- The results for five GSRs are below the statewide rate for *LTCFS Consistency* (53.4 percent): GSRs 2, 7, 8, 11 and 12.
- The results for six GSRs are below the statewide rate for *Rescreen* (33.3 percent): GSRs 3, 4, 7, 9, 12, and 13.

GSR 11 is a contributing factor in five of the six focus areas. GSR 8 contributed to the low scores in four of the six focus areas.

FCP

The FCP program scores lowest in areas of *Comprehensive MCP*, *Timely MCP*, *Essential Providers, Timely Follow-Up*, *IDT Contact, LTCFS Consistency*, and *Rescreen*. Analysis by GSR identifies areas of focus for each CMR indicator. Using the statewide rates for FCP as the benchmark:

- The results for three GSRs are below the statewide rate for *Comprehensive MCP* (83.8 percent): GSRs 6, 8, and 11.
- The results for four GSRs are below the statewide rate for *Timely MCP* (73.5 percent): GSRs 2, 8, 11, and 12.
- The results for three GSRs are below the statewide rate for *Essential Providers* (69.3 percent): GSRs 8, 10, and 11.
- The results for four GSRs are below the statewide rate for *Timely Follow-Up* (51.0 percent): GSRs 2, 8, 12 and 14.
- The results for three GSRs are below the statewide rate for *IDT Contact* (80.6 percent): GSRs 8, 12, and 14.
- The results for five GSRs are below the statewide rate for *LTCFS Consistency* (36.0 percent): GSRs 2, 5, 9, 12 and 14.
- The results for four GSRs are below the statewide rate for *Rescreen* (42.4 percent): GSRs 5, 10, 11, and 12.

GSR 8 contributed to the lower results in five of the seven focus areas. GSR 11 contributed to four of the seven areas.

PACE

The PACE program scores lowest in *Timely Follow-Up, LTCFS Consistency*, and *Rescreen*. Analysis by GSR identifies areas of focus for the CMR indicator. Using the statewide rate for PACE as the benchmark:

- The results for one GSR are below the statewide rate for *Timely Follow-Up* (69.3 percent): GSR 11.
- The results for two GSRs are below the statewide rate for *LTCFS Consistency* (40.8 percent): GSRs 6 and 11.
- The results for two GSRs are below the statewide rate for *Rescreen* (40.0 percent): GSRs 6 and 11.

GSR 11 contributed to the lower results in all three focus areas. GSR 6 contributed to two of the three areas.

Conclusions

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

Appendix A: Information Systems Capabilities Assessment

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

During FY 22-23, MetaStar conducted ISCAs for two MCOs selected by DHS. The organizations were *i*Care, which operates the FCP program; and MCW, which operates the FC and FCP programs.

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

This review was organized around and focused on the following categories:

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

Overall Results

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

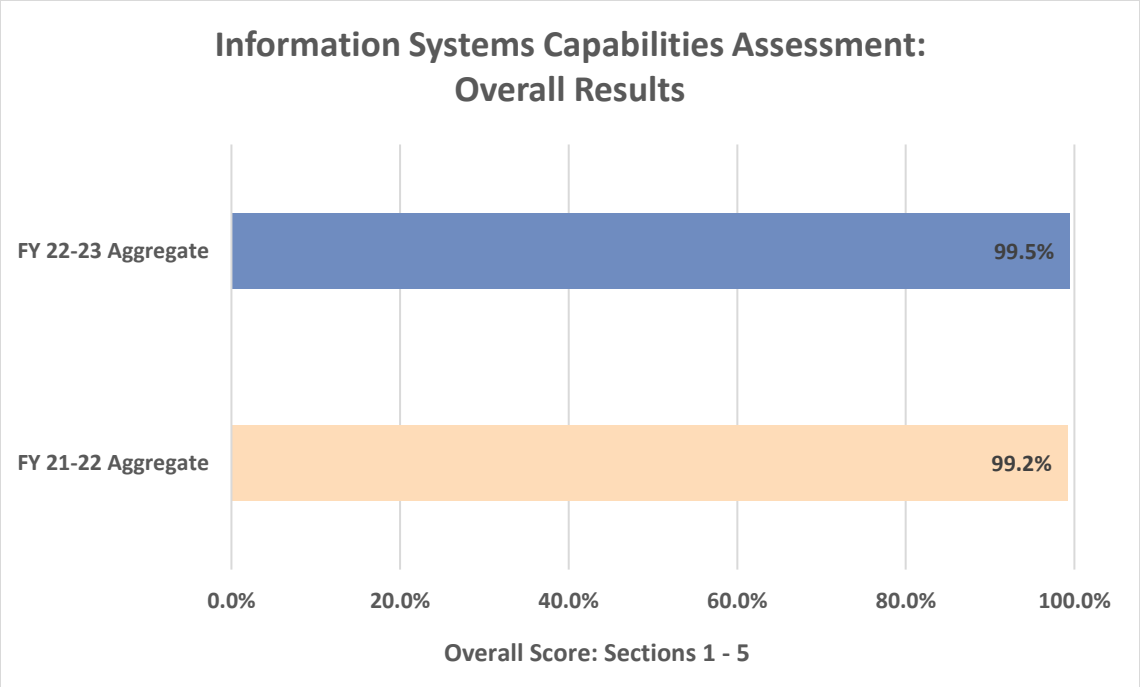
Scoring Legend		
Percentage Met	**Stars**	**Rating**
95.0% - 100.0%	★★★★★	Excellent
90.0% - 94.9%	★★★★½	
85.0% - 89.9%	★★★★	Very Good
80.0% - 84.5%	★★★½	
75.0% - 79.9%	★★★	Good
70.0% - 74.9%	★★½	
65.0% - 69.9%	★★	Fair
60.0% - 64.9%	★½	
55.0%-59.9%	★	Poor
< 54.9%	½	

Aggregately, the MCOs had an overall score of 99.5 percent, and a rating of Excellent. The table below displays the aggregate number of scoring elements for each section, the percentage of scoring elements met, and the rating for each section.

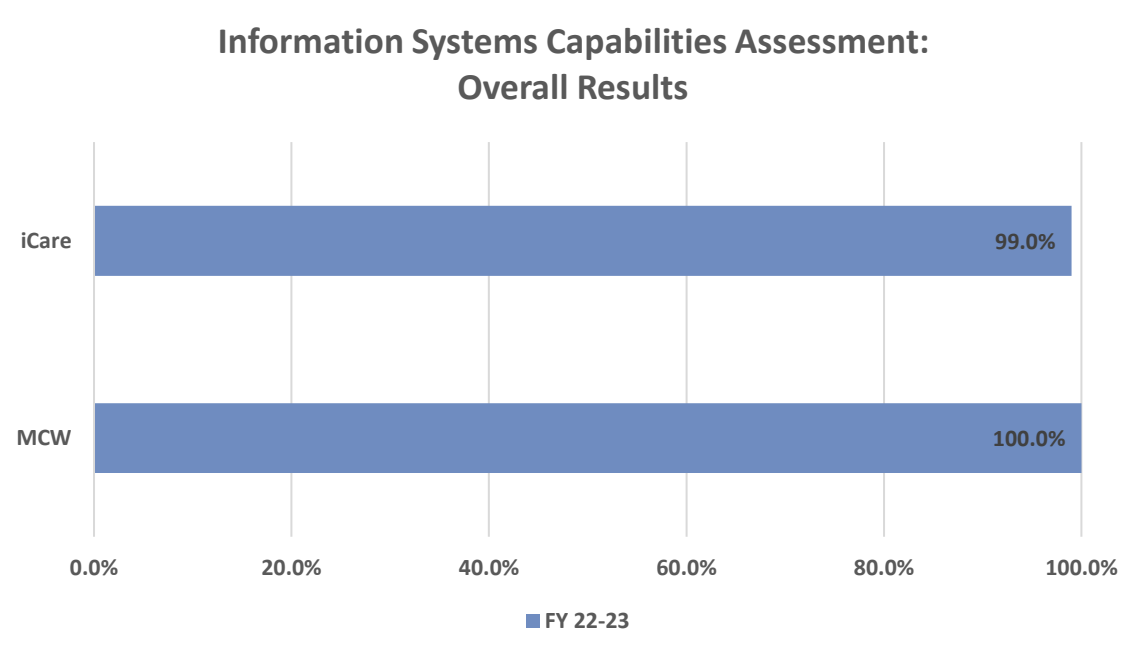
Information Systems Capabilities Assessment FY 22-23				
Focus Area	**Scoring Elements**	**Percentage Met**	**Stars**	**Rating**
Background Information*	N/A	N/A	N/A	N/A
Information Systems	30/30	100.0%	★★★★★	Excellent
Staffing	4/4	100.0%	★★★★★	Excellent
Security	52/52	100.0%	★★★★★	Excellent
Data Acquisition Capabilities	113/114	99.1%	★★★★★	Excellent
Overall	**199/200**	**99.5%**	★★★★★	**Excellent**

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

The graph on the next page illustrates the State's overall compliance with these standards in FY 22-23 and compares the score to the overall compliance score from FY 21-22.



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



Results for each ISCA Focus Area

Observation and Analysis: Section 1. Background Information

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

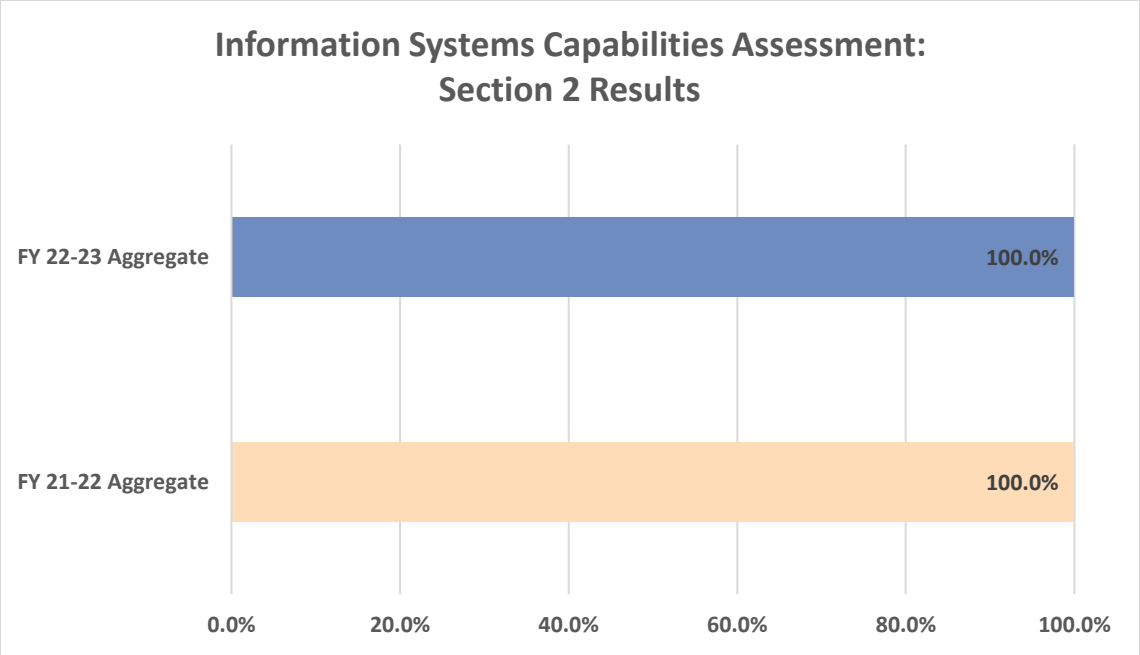
MCO Background Information		
MCO	*i*Care	MCW
Date of Incorporation:	2003	2020
Date of Prior ISCA:	November 2019	N/A*

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

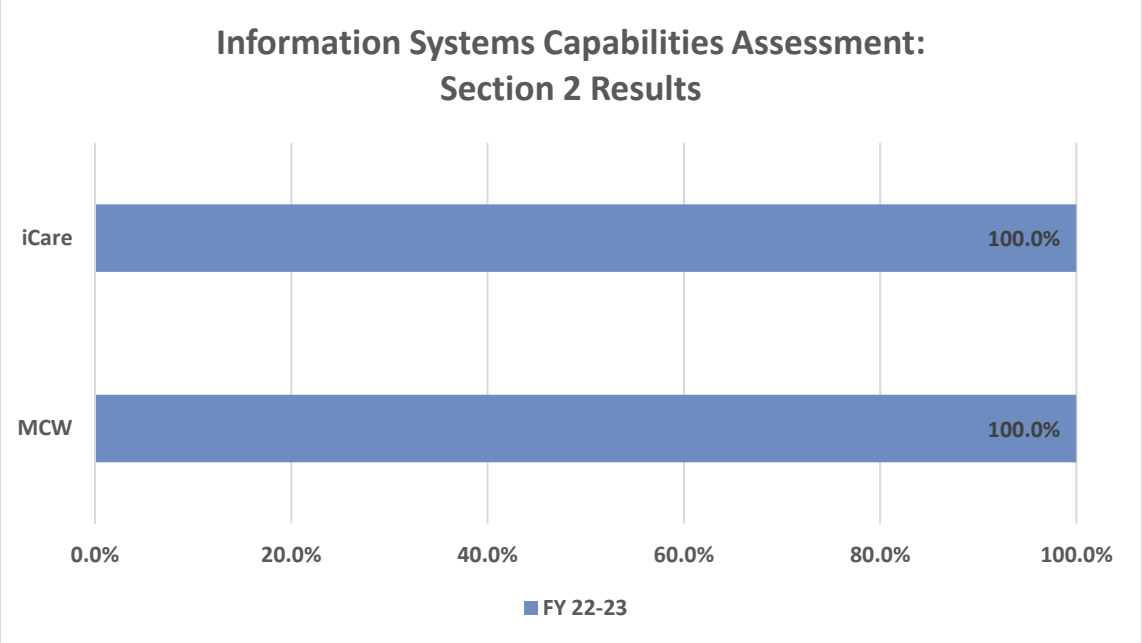
Observation and Analysis: Section 2. Information Systems - Data Processing & Personnel

Each MCO must have a system or repository used to store Medicaid claims and encounter data supported by stable and experienced IS staff. The IS department should follow a standardized process when updating and revising code. This process should include safeguards that ensure that the correct version of a program is in use. Section 2 contains 15 possible scoring elements for each MCO. The MCOs satisfied requirements for 30 out of 30 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The graph on the next page illustrates the State's overall compliance with these standards in FY 22-23 and compares the score to the overall compliance score from FY 21-22.



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



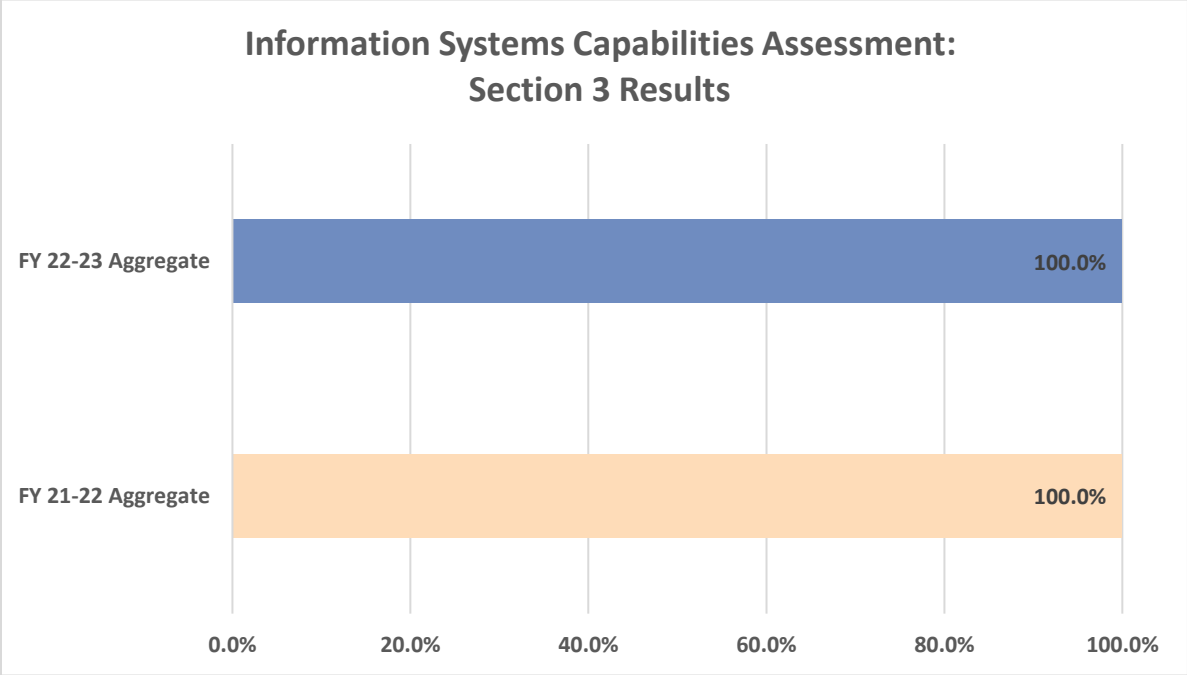
The responses submitted and interview sessions with MCO staff satisfied requirements of this focus area. Both MCOs contract with third-party vendors who gather and process claims and

encounter data to DHS. All organizations use version control software for change management and deployment to the production environment, and follow a documented production change control process prior to modifying any code. When changes to the claims, encounter, or enrollment tracking systems are required, each MCO undertakes a strategic and priority driven approach to implement and test the change prior to production.

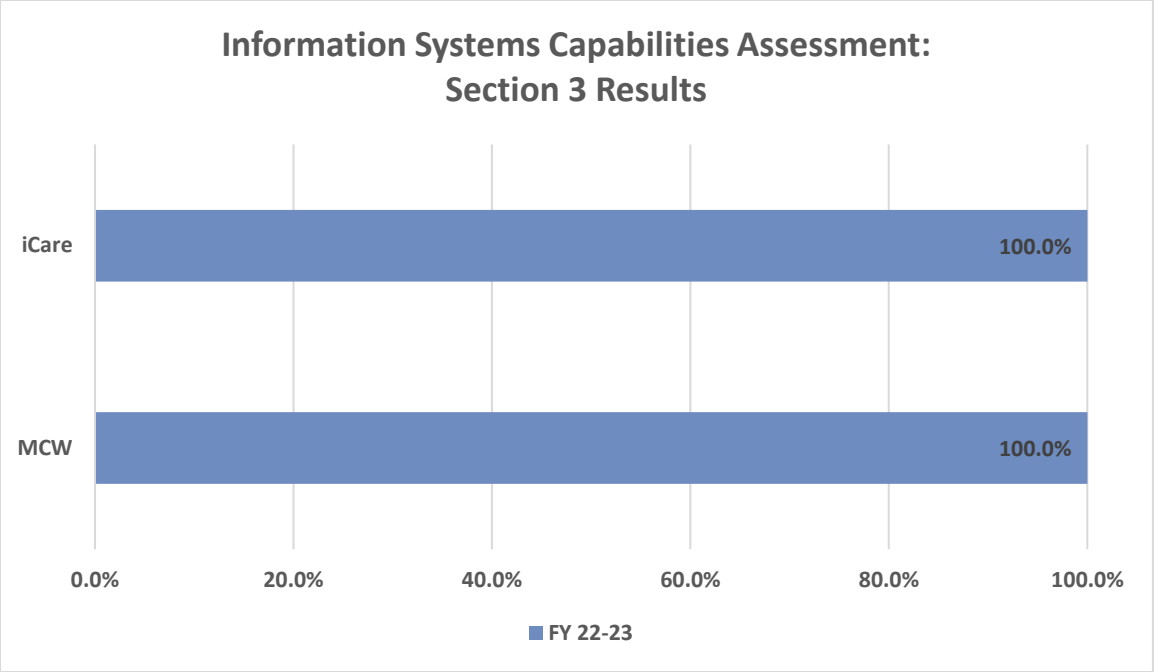
Observation and Analysis: Section 3. Staffing

Each MCO's IS department must provide its new employees with on-the-job training and supervision. Supervisors should closely audit the work of new hires before concluding the training process. Seasoned processors should have occasional refresher courses and training concerning any system modifications. Expected productivity goals should not be unusually high, thus having a negative impact on the accuracy and quality of a processor's work. Section 3 contains two possible scoring elements for each MCO. The MCOs satisfied requirements for four out of four scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The graph below illustrates the State's overall compliance with these standards in FY 22-23 and compares the score to the overall compliance score from FY 21-22.



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

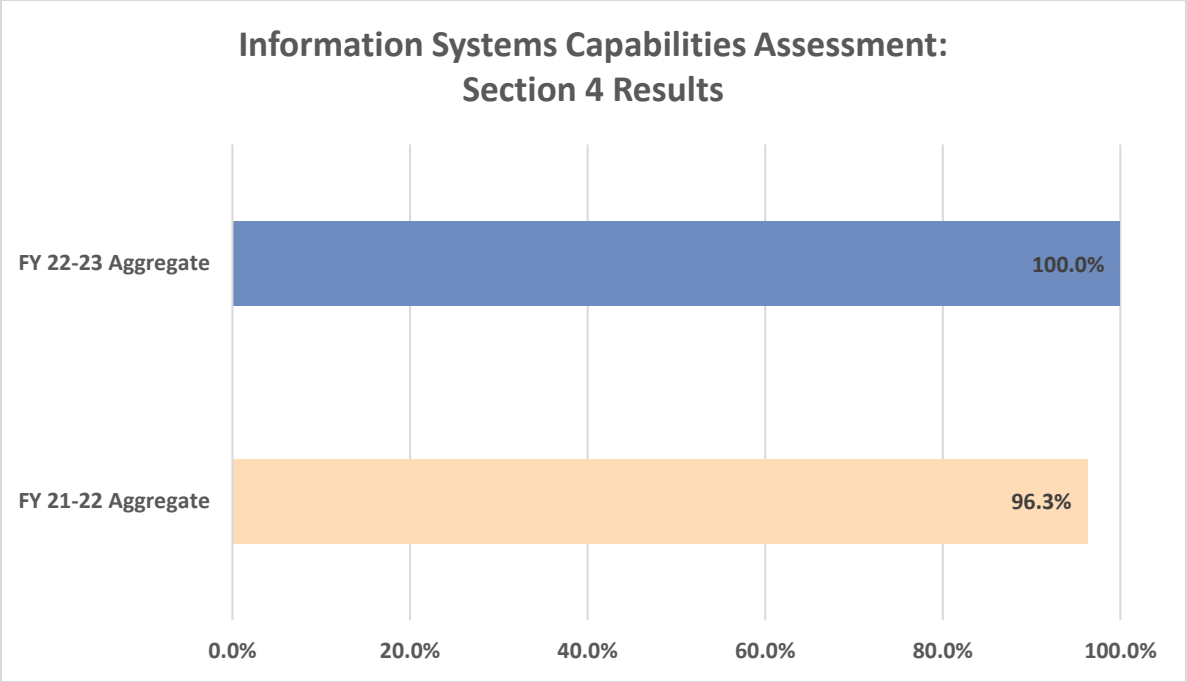


The responses submitted and interview sessions with MCO staff satisfied requirements of this focus area. Each organization has designed a training program for new hires based on the needs and skill sets of the individual, which involves virtual training, mentoring, and shadowing current staff. Validation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

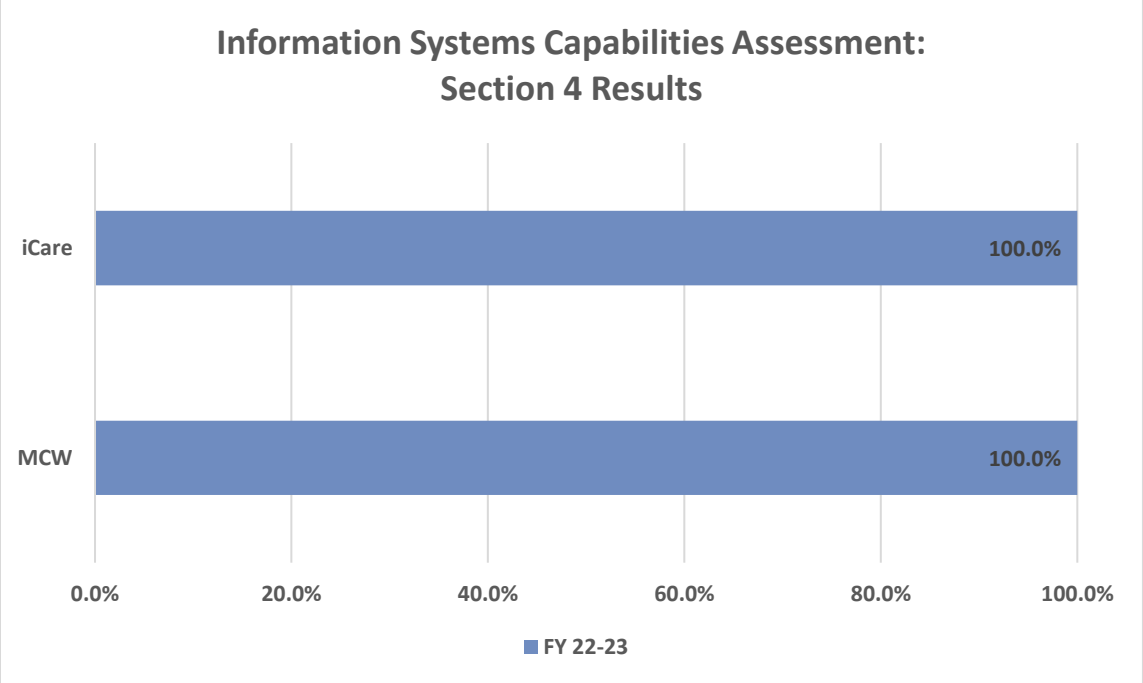
Observation and Analysis: Section 4. Security

Each MCO must have strong IS security controls that protected from both unauthorized usage and accidental damage. Practices must be in place to manage its encounter data security processes and ensure the data integrity of submissions. MCOs should have data backing and disaster recovery procedures, including testing. Section 4 contains 26 possible scoring elements for each MCO. The MCOs satisfied requirements for 52 out of 52 scoring elements, for a score of 100.0 percent, and a rating of Excellent.

The graph on the next page illustrates the State's overall compliance with these standards in FY 22-23. and compares the score to the overall compliance score from FY 21-22.



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

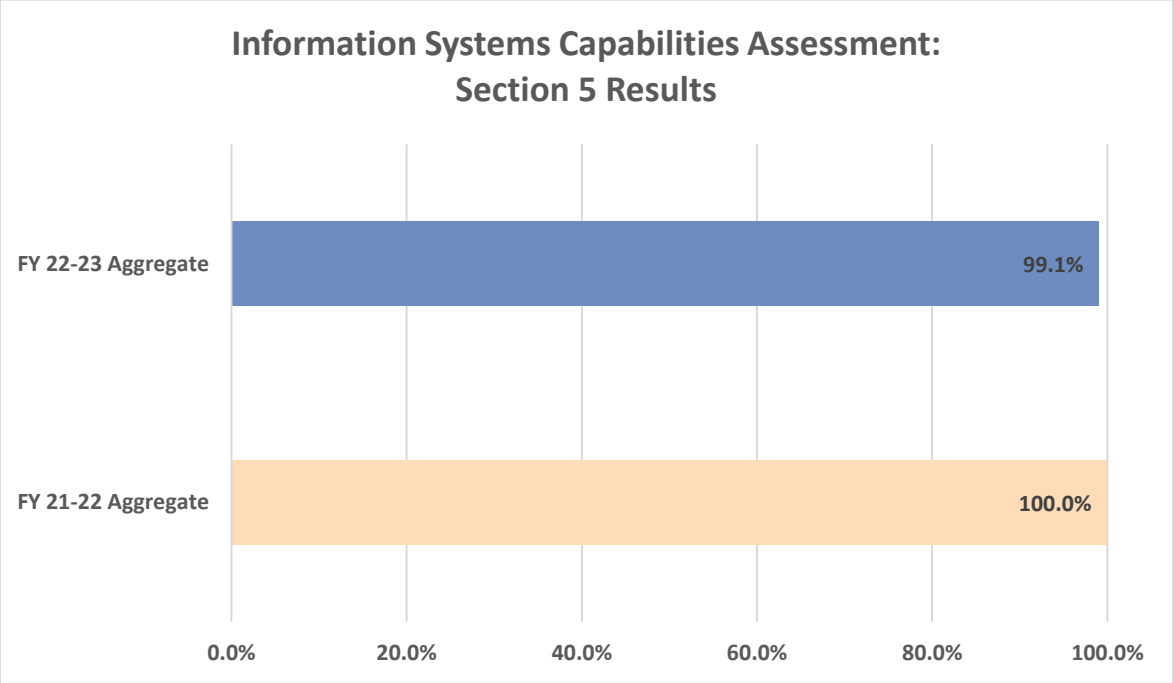


The responses submitted and interview sessions with MCO staff satisfied requirements of this focus area. Each MCO has a disaster recovery system to enable each organization to keep business functioning running in the event of a disaster or failover. Physical security of information was adapted by each MCO due to the Public Health Emergency (PHE) and *Wisconsin's Safer at Home* order during the Coronavirus-2019 (COVID-19) pandemic. Productivity and accuracy of work is monitored, and each organization's physical security practices and policies have remained in place regardless of whether staff are working remotely or in the office.

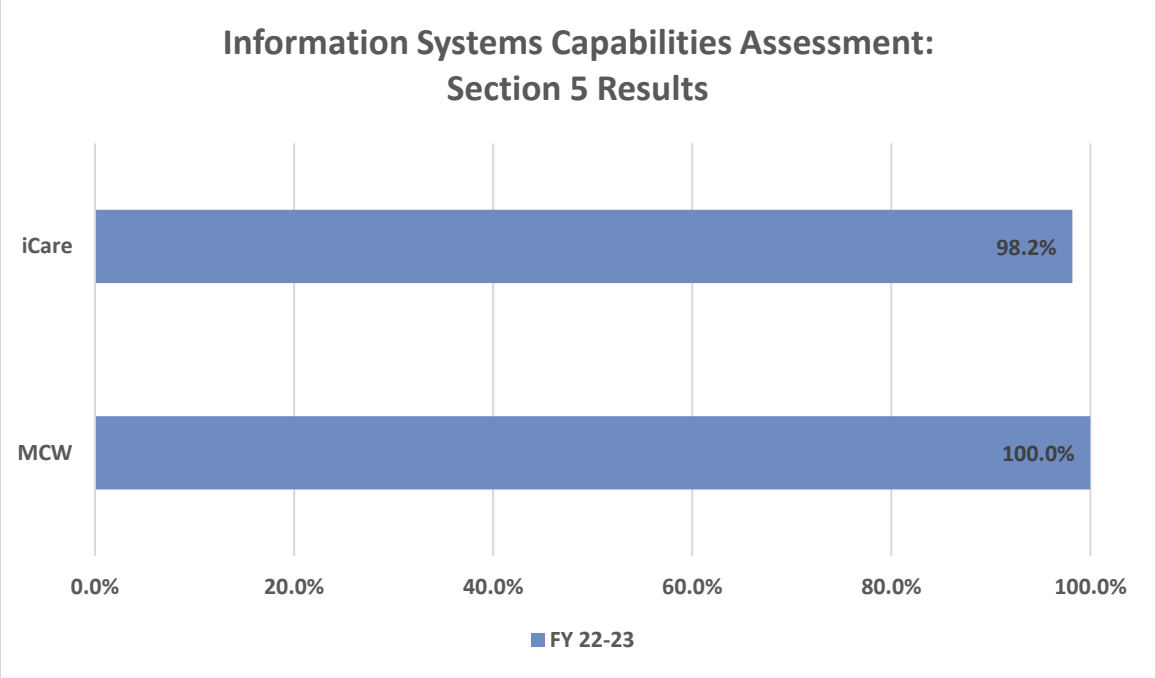
Observation and Analysis: Section 5. Data Acquisition Capabilities

MCOs must have consistent processes for collecting and maintaining administrative data (claims and encounter data), enrollment data, ancillary services data and data related to performance rates reporting. Section 5 contains 57 possible scoring elements for each MCO. The MCO satisfied requirements for 113 out of 114 scoring elements, for a score of 99.1 percent, and a rating of Excellent.

The graph below illustrates the State's overall compliance with these standards in FY 22-23 and compares the score to the overall compliance score from FY 21-22.



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



5A. Administrative Data (Claims and Encounter Data)

This section focuses on input data sources, such as electronic and paper claims, and on the transaction systems utilized by the MCOs.

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

5B. Enrollment System

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

The responses submitted and interview sessions met requirements of this focus area. Each MCO has the systems and processes in place to accurately collect, manage, and retain the eligibility, enrollment, and disenrollment data. Unique member identification numbers remain

linked to members throughout their enrollment in any program provided by each organization, and systems are in place to flag and eliminate duplicate member identification numbers.

5C. Ancillary Systems

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

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

5D. Additional Data Sources that Support Quality Reporting

This section focuses on data sources beyond third party collection of claims or encounter data that support quality reporting.

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

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

This section focuses on how the MCO integrates Medicaid claims, encounter, membership, provider, third-party, and other data to calculate performance rates.

The responses submitted and interview sessions with MCO staff satisfied requirements of this focus area. Each organization's quality department staff extract vaccination data entered into their electronic care management systems for DHS performance measure reporting requirements. Both MCOs met all requirements for calculating and reporting measures.

Appendix 1 – List of Acronyms

CCI	Community Care, Inc., Managed Care Organization
CFR	Code of Federal Regulations
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CW	Care Wisconsin, Managed Care Organization
COVID-19	Coronavirus Disease-2019
DHS	Wisconsin Department of Health Services
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Family Care
FCP	Family Care Partnership
FY	Fiscal Year
GSR	Geographic Service Region
HCBS	Home and Community Based Services Waivers
HEDIS[1]	Healthcare Effectiveness Data and Information Set
*i*Care	Independent Care Health Plan, Managed Care Organization
IDT	Interdisciplinary Team
Inclusa	Inclusa, Inc., Managed Care Organization
IS	Information System(s)
ISCA	Information Systems Capabilities Assessment
LCI	Lakeland Care, Inc., Managed Care Organization
LTSS	Long-term services and supports
MCO	Managed Care Organization
MCP	Member-Centered Plan

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

MCW	My Choice Wisconsin, Inc., Managed Care Organization
MY	Measurement Year
NCQA	National Committee for Quality Assurance
PACE	Program of All-Inclusive Care for the Elderly
PIP	Performance Improvement Project (Validation of Performance Improvement Projects)
PMV	Performance Measures Validation (Validation of Performance Measures)
PIHP	Prepaid Inpatient Health Plan
QAPI	Quality Assessment and Performance Improvement
QCR	Quality Compliance Review
RAD	Resource Allocation Decision
SDS	Self-Directed Supports

Appendix 2 – Requirement for External Quality Review and Review Methodologies

Requirement for External Quality Review

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

MetaStar - Wisconsin's External Quality Review Organization

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

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

MetaStar Review Team

The MetaStar EQR team is comprised of registered nurses, a physical therapist, counselors, licensed and/or certified social workers, and other degreed professionals with extensive education and experience working with the target groups served by the MCOs. The EQR team is supported by other members of MetaStar's External Quality Review Department as well as staff in other departments, including a data analyst with an advanced degree, a licensed Healthcare Effectiveness Data and Information Set (HEDIS®)[2] auditor, and information technologies staff.

[2] "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 used sound methodology in the design, implementation, analysis and reporting of its PIPs. The MetaStar team evaluated the MCO PIPs according to the methodology described in the CMS guide, *EQR Protocol 1: Validating Performance Improvement Projects (PIPs), A Mandatory EQR-Related Activity.*

Reviewers evaluated the PIP's design, implementation, analysis and reporting using each of the following standards for the MCO'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

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

1. Standard 1: PIP Topic

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

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

Each section has a specified number of scoring elements, which correlate with the *CMS EQR Protocol 1, Validation of Performance Improvement Projects.* Standard scores are presented as the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score for each standard.

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

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

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

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

Validating performance measures is a mandatory EQR activity used to assess the accuracy of performance measures reported by the MCO, and to determine the extent to which performance measures calculated by the MCO follow state definitions 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, A Mandatory Protocol for External Quality Reviews (EQR), February 2023.*

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

Each MCO submitted data to MetaStar using standardized templates developed by DHS. The templates included vaccination data for all members that the MCO determined met criteria for inclusion in the denominator.

MetaStar reviewed the validity of the data and analyzed the reported vaccination rates for each quality indicator and program the MCO administered during the specified measurement year (MY). To complete the validation work, MetaStar:

- Reviewed each data file to ensure there were no duplicate records.
- Confirmed that the members included in the denominators met the technical definition requirements established by DHS, including:
    - Ensuring members reported to have contraindications were appropriately excluded from the denominator; and
    - Confirming vaccination data reported for members that met specified age requirements.
- Verified that members included in the numerators met the technical definition requirements established by DHS, ensuring that vaccinations were given within the identified timeframe.
- Determined the total number of unique members in the MCO and DHS denominators and calculated the number and percentage that were included in both data sets. If the denominator was not within five percentage points of DHS' denominator, the MCO was required to resubmit data.

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

MetaStar randomly selected 30 members per indicator from each program operated by the MCO to verify the accuracy of the MCO's reported data. MetaStar took the following steps:

- Reviewed each member's care management record to verify documentation of vaccinations, exclusions, and contraindications as defined by the technical definitions.
- Documented whether the MCO's report of the member's vaccination or exclusion was valid or invalid (the appropriate vaccination was documented for the current measurement year or the MCO provided documentation for the exclusion).
- Conducted statistical testing to determine if rates were unbiased, meaning that they can be accurately reported. (The logic of the t-test is to statistically test the difference between the MCO's estimate of the positive rate and the audited estimate of the positive rate. If MetaStar validated a sample [subset] from the total eligible population for the measure, the t-test determined bias at the 95 percent confidence interval.)

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

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

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

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

- The MCO's current Family Care Program contracts with DHS;
- Related program operation references found on the DHS website:

- https://www.dhs.wisconsin.gov/familycare/mcos/index.htm ;
- The previous external quality review report; and
- DHS communication with the MCO about expectations and performance during the previous 12 months.

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

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

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

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

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

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

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

Scoring Legend		
Percentage Met	**Stars**	**Rating**
95.0% - 100.0%	★★★★★	Excellent
90.0% - 94.9%	★★★★½	
85.0% - 89.9%	★★★★	Very Good
80.0% - 84.5%	★★★½	
75.0% - 79.9%	★★★	Good
70.0% - 74.9%	★★½	
65.0% - 69.9%	★★	Fair
60.0% - 64.9%	★½	

Scoring Legend		
Percentage Met	**Stars**	**Rating**
55.0%-59.9%	★	Poor
< 54.9%	½	

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

Compliant:

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

Not Compliant:

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

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

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

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

In addition, members from all target populations served by the MCO were included in the random sample: frail elders, and persons with physical and intellectual/developmental disabilities, including some members with mental illness, traumatic brain injury, and Alzheimer's disease.

As directed by DHS, MetaStar also reviewed the records of any members identified in last year's CMR as having health and safety issues and/or complex and challenging situations. The results of these individual record reviews were provided to DHS and to the MCO, but were not included in the FY 22-23 aggregate results.

Prior to conducting the CMR, MetaStar obtained and reviewed policies and procedures from the MCO, to familiarize reviewers with the MCO's documentation practices.

During the review, MetaStar scheduled regular communication with quality managers or other MCO representatives to:

- Request additional documentation if needed;
- Schedule times to speak with care management staff, if needed;
- Update the MCO on record review progress; and
- Inform the MCO of any potential or immediate health or safety issues or members of concern.

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

- Comprehensive Assessment
- Member-Centered Planning
- Care Coordination
- Long-Term Care Functional Screen
- Quality of Care

MetaStar initiated a *Quality Concern Protocol* if there were concerns about a member's immediate health and safety, or if the review identified complex and/or challenging circumstances that warranted additional oversight, monitoring, or assistance. MetaStar communicated findings to DHS and the MCO if the *Quality Concern Protocol* was initiated.

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

EQR Protocols Appendix A: Information Systems Capabilities Assessment

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

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

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

To conduct the assessment, MetaStar used the information systems capabilities assessment (ISCA) scoring tool to collect information about the effect of the 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.

Interview sessions were then held 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 correlates with the *CMS External Quality Review (EQR) Protocol Appendix A. Worksheet A.1 Information System Capabilities Assessment (ISCA) Tool*. Standard scores are presented as the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score:

Scoring Legend		
Percentage Met	**Stars***	**Rating**
95.0% - 100.0%	★★★★★	Excellent
90.0% - 94.9%	★★★★½	
85.0% - 89.9%	★★★★	Very Good
80.0% - 84.5%	★★★½	
75.0% - 79.9%	★★★	Good
70.0% - 74.9%	★★½	
65.0% - 69.9%	★★	Fair

Scoring Legend		
Percentage Met	**Stars***	**Rating**
60.0% - 64.9%	★½	
55.0% - 59.9%	★	Poor
< 54.9%	½	

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 MCO's IS and business operations.

Section 1: Background Information

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

Section 3: Staffing

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

Section 4: Security

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

Section 5: Data Acquisition Capabilities

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

Appendix 3 – Quality Compliance Review: FY 22 - 23 MCO Comparative Scores

Standard	Citation	Managed Care Programs FY 22 - 23				
		CCI	**Inclusa**	***i*Care**	**LCI**	**MCW**
M1	*Availability of services - 42 CFR 438.206*	87.5%	100.0%	100.0%	100.0%	100.0%
M2	*Timely access to services - 42 CFR 438.206(c)(1)*	100.0%	100.0%	100.0%	100.0%	100.0%
M3	*Cultural considerations in services - 42 CFR 438.206(c)(2)*	100.0%	100.0%	100.0%	100.0%	100.0%
M4	*Network adequacy - 42 CFR 438.207*	100.0%	100.0%	100.0%	100.0%	100.0%
M5	*Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224*	91.7%	91.7%	91.7%	91.7%	91.7%
M6	*Coordination and continuity of care, and confidentiality - 42 CFR 438.208, 42 CFR 438.224*	80.0%	80.0%	80.0%	90.0%	90.0%
M7	*Disenrollment: requirements and limitations - 42 CFR 438.56*	100.0%	100.0%	100.0%	75.0%	100.0%
M8	*Coverage and authorization of services - 42 CFR 438.210, 42 CFR 440.230, 42 CFR 438.441*	100.0%	100.0%	100.0%	100.0%	100.0%
M9	*Information requirements for all enrollees - 42 CFR 438.100(b)(2)(i), 42 CFR 438.10*	91.7%	100.0%	100.0%	100.0%	100.0%
M10	*Enrollee right to receive information on available provider options - 42 CFR 438.100(b)(2)(iii), 42 CFR 438.102*	100.0%	75.0%	100.0%	100.0%	100.0%
M11	*Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint - 42 CFR 438.100(b)(2)(iv) and (v), 42 CFR 438.3(j)*	100.0%	90.9%	100.0%	100.0%	100.0%
M12	*Compliance with other federal and state laws - 42 CFR 438.100(d)*	100.0%	100.0%	100.0%	100.0%	100.0%
M13	*Provider selection - 42 CFR 438.214*	92.3%	76.9%	100%	92.3%	100.0%
M14	*Subcontractual relationships and delegation - 42 CFR 438.230*	100.0%	100.0%	100.0%	100.0%	100.0%
M15	*Practice guidelines - 42 CFR 438.236*	100.0%	100.0%	100.0%	75.0%	100.0%
M16*	*Health information systems – 42 CFR 438.242*	NA	NA	NA	NA	NA
Overall		**94.9%**	**92.7%**	**97.4%**	**95.4%**	**98.3%**

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

Appendix 4 – Care Management Review: FY 2022 – 2023 MCO Comparative Scores

Family Care Program

Indicator #	Indicator Description	Managed Care Programs FY 22-23			
		CCI	Inclusa	LCI	MCW
1A	Comprehensive Assessment	83.1%	76.4%	93.9%	92.9%
1B	Timely Assessment	94.8%	95.9%	96.9%	93.2%
2A	Comprehensive MCP	52.1%	81.6%	71.6%	85.7%
2B	Timely MCP	80.5%	86.9%	86.2%	84.6%
2C	MCP Signed Annually	95.1%	99.3%	97.3%	95.9%
2D	Change in Condition	87.2%	90.0%	87.8%	93.2%
2E	Service Authorizations	94.8%	92.1%	90.0%	91.7%
2F	Essential Providers	76.2%	78.9%	90.0%	87.1%
3A	Timely Coordination	94.0%	98.1%	97.3%	96.2%
3B	Timely Follow-Up	61.0%	52.1%	56.7%	58.3%
3C	Member Rights	98.1%	99.3%	98.1%	97.0%
3D	IDT Contact	88.0%	87.3%	91.2%	87.6%
4A	LTCFS Consistency	52.4%	50.6%	59.8%	51.1%
4B	Rescreen	39.3%	43.5%	9.5%	37.0%
5A	Needs Addressed	99.3	100.0%	100.0%	99.2%
Overall		**82.1%**	**84.5%**	**86.4%**	**86.0%**

Family Care Partnership Program

Indicator #	Indicator Description	Managed Care Programs FY 22-23		
		CCI	*i*Care	MCW
1A	Comprehensive Assessment	81.5%	92.5%	86.3%
1B	Timely Assessment	90.0%	87.7%	91.6%
2A	Comprehensive MCP	74.5%	83.8%	92.1%
2B	Timely MCP	70.5%	81.1%	73.6%
2C	MCP Signed Annually	90.5%	92.5%	94.7%
2D	Change in Condition	80.0%	87.5%	90.0%
2E	Service Authorizations	90.0%	90.4%	89.0%
2F	Essential Providers	65.2%	60.5%	82.0%

Indicator #	Indicator Description	Managed Care Programs FY 22-23		
		CCI	*i*Care	MCW
3A	Timely Coordination	92.0%	89.5%	94.7%
3B	Timely Follow-Up	50.5%	46.5%	56.4%
3C	Member Rights	93.0%	96.9%	96.0%
3D	IDT Contact	84.0%	75.9%	82.4%
4A	LTCFS Consistency	38.5%	50.0%	19.8%
4B	Rescreen	43.5%	76.5%	10.5%
5A	Needs Addressed	99.0%	97.4%	99.1%
Overall		**78.3%**	**81.0%**	**81.1%**

Program of All-Inclusive Care for the Elderly

Indicator #	Indicator Description	Managed Care Programs
		CCI
1A	Comprehensive Assessment	92.2%
1B	Timely Assessment	95.0%
2A	Comprehensive MCP	92.7%
2B	Timely MCP	87.7%
2C	MCP Signed Annually	99.4%
2D	Change in Condition	93.5%
2E	Service Authorizations	93.9%
2F	Essential Providers	93.0%
3A	Timely Coordination	94.4%
3B	Timely Follow-Up	69.3%
3C	Member Rights	99.4%
3D	IDT Contact	92.2%
4A	LTCFS Consistency	40.8%
4B	Rescreen	40.0%
5A	Needs Addressed	99.4%
Overall		**87.9%**