MetaStar

External Quality Review

Fiscal Year 2023 – 2024

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Division of Medicaid Services

Annual Technical Report

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

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External Quality Review Organization
MetaStar, Inc. Suite 300 2909 Landmark Place Madison, Wisconsin 53713
Prepared by staff in the External Quality Review Department
Primary Contacts
Jenny Klink, MA, CSW Vice President 608-441-8216 jklink@metastar.com
Alicia Stensberg, MA Project Manager 608-441-8255 astensbe@metastar.com
Don Stanislawski, BS Project Coordinator 608-441-8204 dstanisl@metastar.com

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Executive Summary

Background

Wisconsin Department of Health Services (DHS) has provided long-term care services to adults with developmental and physical disabilities, and elderly individuals through a managed care model since the 1990s. In 1990, the Program of All-Inclusive Care for the Elderly (PACE) was implemented to help older adults and people over age 55 with disabilities. PACE is a national joint Medicare and Medicaid program that provides eligible adults with health care, long-term care, and prescription drugs. In 1995, Wisconsin began redesigning the long-term care system for older adults and adults with disabilities who qualify for institutional levels of care and individuals eligible for full benefit Medicare and Medicaid, by creating Family Care Partnership. Family Care Partnership provides members with Medicaid long-term care services and supports and Medicare acute care benefits through Medicare Advantage Special Needs Plans. In 1998, the Family Care program, which provides all Medicaid-covered long-term care services and supports to people who qualify for, or are at risk of, an institutional level of care, began as a pilot program in five counties in Wisconsin, and has since expanded to all 72 Wisconsin counties and has reached full entitlement.

These three programs are offered in Wisconsin to provide long-term services and supports through managed care to adults with developmental and physical disabilities, and elderly individuals. All programs in Wisconsin operate with the goals of improving access, member choice, and health equity.

The Code of Federal Regulations (CFR) at 42 CFR 438 requires states that operate prepaid inpatient health plans and managed care organizations to conduct external quality review of these organizations and to produce an annual technical report. To meet its obligations, the State of Wisconsin, DHS contracts with MetaStar, Inc. Review activities are planned and implemented according to The Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols. This is the annual technical report that the State of Wisconsin must provide to the CMS related to the operation of its Medicaid managed health and long-care programs. See Appendix 2 for more information about external quality review and a description of the methodologies used to conduct review activities.

Scope of External Review Activities

This report covers the external quality review fiscal year from July 1, 2023 to June 30, 2024 (FY 23-24). 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.

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 2023.

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 2023. 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 4: Validation of Network Adequacy

Network Adequacy Validation is a mandatory activity, identified in 42 CFR 438.68. The review assesses the capabilities of each managed care organization's provider network to ensure each are sufficient to provide timely and accessible care to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries across the continuum of services. 42 CFR 438.68 requires states to set quantitative network adequacy standards that account for regional factors and the needs of the state's managed care programs populations. This is a new protocol, implemented in FY 23-24.

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.

State-Level Analysis: Quality, Timeliness, and Access

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

- Quality: The degree to which a program increases the likelihood of desired outcomes to its members through (1) its structural and operational characteristics, (2) the provision of service that are consistent with current professional, evidenced-based knowledge, and (3) interventions for performance improvement.
- Timeliness: Reducing wait and sometimes harmful delays, and is interrelated with safety, efficiency, and patient-centeredness of care.

- Access: The timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for availably and timeliness elements.

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

Protocol 1: Validation of Performance Improvement Projects			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths Identified: – All topics targeted improvement in relevant areas of clinical and non-clinical services. – Aim statements identified the focus of each project and established the necessary framework. – All projects clearly defined the project populations. – Variables and performance measures were adequate to answer the project aims and were able to measure performance and track improvement over time. – Data collection procedures identified appropriate data to be collected. – Appropriate techniques were used for data analysis and interpretation of project results. – Improvement strategies were evidence-based and included assessment of the effectiveness of the strategies. Progress Identified from EQR FY 22-23 Recommendations : – All aim statements specified the time period for each project. – Each aim statement was answerable. Recommendations Identified: – Ensure the same methodology is used to calculate the baseline and repeat measurements for each project. – Implement improvement strategies that will lead to the desired improvements in the selected topic.

Protocol 2: Validation of Performance Measures			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths Identified: – The Family Care Partnership and PACE programs demonstrated practices to ensure members receive pneumococcal vaccinations after the age of 65.

Protocol 2: Validation of Performance Measures			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			Progress Identified from EQR FY 22-23 Recommendations: – The Family Care Partnership program demonstrated improvement in ensuring members receive pneumococcal vaccinations after the age of 65. Recommendations Identified: - Conduct a root cause analysis to identify the declining influenza rates for all programs. Rates have declined for four consecutive years, with Family Care experiencing a statistically significant decline in the prior two measurement years when compared to vaccinations rates from the year before. - Continue efforts to increase influenza vaccination rates by educating members on the benefits of receiving vaccinations, to ensure members stay as healthy as possible.

Protocol 3: Compliance with Managed Care Regulations			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths Identified: – The organizations have quality management programs that include robust plans for documentation and monitoring of required activities. These are goal-driven plans attempting to improve the access, timeliness, and quality of supports to members. – The organizations have grievance and appeal systems in place that include required internal grievance processes, appeal processes, and access to the State's Fair Hearing system. These systems also include policies in place that ensure appropriate authority to file, as well as required timeframes to be adhered to. Progress Identified from EQR FY 21-22 Recommendations: – No progress was identified in this year's review. Recommendations Identified: – Continue to focus on the implementation of monitoring specific to member choice and verifying the inclusion of members and legal decision makers in the care planning process. – Focus efforts to ensure the current and accurate *Notice of Adverse Benefit Determination* forms are being used. – Continue to focus on improving the timeliness of issuing notices of action for benefit determinations, and implement monitoring in order to better recognize when notices are indicated.

Protocol 4: Validation of Network Adequacy			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths Identified: – All organizations demonstrated consistent and reliable data collection procedures for all state standards. – All organizations demonstrated consistent and reliable network adequacy methods for all state standards and results Progress Identified from EQR FY 22-23 Recommendations: – Protocol 4 was implemented in FY 23-24; therefore, there are no prior results for comparison. Recommendations Identified: – Improve the network of providers in the following service types that did not meet the member to provider ratio standard in all counties for the Family Care program: ○ Community Support Program ○ Mental Health Day Treatment ○ Supported Employment – Small Group ○ Adult Day Care ○ Adult Residential Care - 1-2 Bed Adult Family Home) ○ Prevocational Services ○ Occupational Therapy ○ Speech and Language Pathology Services – Improve the network of providers in the following service types that did not meet the member to provider ratio standard in all counties for the Family Care Partnership program: ○ Adult Residential Care – Residential Care Apartment Complex ○ Transportation (Excluding Ambulance) ○ Alcohol and Other Drug Abuse Treatment ○ Counseling and Therapeutic Resources ○ Mental Health Day Treatment ○ Prevocational Services ○ Supported Employment – Small Group ○ Transportation (Specialized) – Other – Improve the network of Mental Health Day Treatment providers in the PACE program to ensure the service category is meeting the member to provider ratio standard in all counties.

Protocol 9: Conducting Focused Studies of Health Care Quality – Care Management Review			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓	✓	Strengths Identified: – All programs demonstrated the ability to sufficiently support members, as evidenced by no members identified with unaddressed health and safety issues.

Protocol 9: Conducting Focused Studies of Health Care Quality – Care Management Review			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			– All programs demonstrated strengths related to ensuring timely assessments. – Member-centered plans were reviewed annually in all programs. – All programs re-assessed and updated member-centered plans for changes in condition, when needed. – Practices to authorize services were evidenced in all programs. – All programs demonstrated the ability to coordinate services timely for members. – Upholding member rights was evidenced in all programs. Progress Identified from EQR FY 22-23 Recommendations: – Timeliness of assessments was improved in the Family Care Partnership program. – Practices related to essential providers were improved in the Family Care Partnership program. – Practices to comply with member contacts were improved in the Family Care Partnership program. Recommendations Identified: – Focus efforts to improve the comprehensiveness of assessments in the Family Care and Family Care Partnership programs. – Improve comprehensiveness of member-centered plans in the Family Care and Family Care Partnership programs. – Improve timeliness of member-centered plans in all programs. – Ensure essential provider requirements are satisfied in the Family Care and Family Care Partnership programs. – Conduct a root cause analysis to identify the cause and barriers to improving the timeliness of follow-up to member services in all programs. – Ensure minimum contact with members is being conducted in the Family Care and Family Care Partnership programs. – Focus efforts on improving the consistency between the Long Term Care Functional Screen and organization documentation in all programs. – Improve practices to conduct rescreens when warranted in all programs.

Appendix A: Information Systems Capabilities Assessments			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
✓	✓		Strengths Identified:

Appendix A: Information Systems Capabilities Assessments			
Quality	**Timeliness**	**Access**	**Strengths, Progress, and Recommendations**
			– Strong systems are maintained and updated by stable and experienced information system departments. – Robust and ongoing training and service level agreements with third party administrators were in place to ensure all Medicaid data is processed accurately and within 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. Progress Identified from EQR FY 22-23 Recommendations: – No progress noted as there were no recommendations identified in the previous year's review. Recommendations Identified: – No recommendations were identified as all programs reviewed achieved 100.0 percent compliance.

State Quality Strategy

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

Wisconsin DHS utilizes three types of strategies[1]:

- Payment – A value-based reimbursement arrangement is used to align payment to outcomes. These arrangements include pay-for-performance initiatives for clinical measures, member satisfaction scores, member engagement in Competitive Integrated Employment, and quality of Assisted Living Communities; and reducing potentially preventable hospital readmissions.
- Delivery System and Person-Centered Care - Delivery system strategies focus on the way organizations care for members. These strategies emphasize care management and coordination, use of health homes and medical homes for specific conditions and populations, and continual attention to the health and safety of Medicaid members.

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

Person-centered care strategies focus on building partnerships between members and their care teams and emphasize high-quality, evidence-based, accessible care in which individual needs, preferences, and values of members and caretakers are paramount.

- Member Engagement and Choice - Member engagement and choice are critical strategies for promoting active participation of members in their own health care decisions, encouraging appropriate utilization of benefits, and ensuring that members receive services and supports according to their needs and preferences. These strategies involve providing culturally competent member services, objective information about care options, and support for employment.

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

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

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
Enhance Value-Based Purchasing	Practices to authorize services were evidenced in all programs.	No recommendations related to this strategy were identified.
Reduce Avoidable, Non-Value Added Care	No strengths related to this strategy were identified.	Focus efforts on improving the consistency between the Long Term Care Functional Screen and organization documentation in all programs.

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
		Improve practices to conduct rescreens of the Long Term Care Functional Screen when warranted in all programs.
Enhance Care Coordination and Person-Centered Care	All programs demonstrated strengths related to ensuring timely assessments and the annual review of member-centered plans. All programs demonstrated the ability to coordinate services timely for members.	Focus efforts to improve the comprehensiveness of assessments and member-centered plans. Ensure essential provider requirements are satisfied in the Family Care and Family Care Partnership programs. Conduct a root cause analysis to identify the cause and barriers to improving the timeliness of follow-up to member services in all programs. Ensure minimum contact with members is being conducted.
Ensure Health and Safety	All programs demonstrated the ability to sufficiently support members, as evidenced by no members identified with unaddressed health and safety issues.	No recommendations related to this strategy were identified.
Promote Member Engagement	The organizations have quality management programs that include robust plans for documentation and monitoring of required activities. These are goal-driven plans attempting to improve the access, timeliness, and quality of supports to members.	No recommendations related to this strategy were identified.
Long-Term Care Choice	Upholding member rights was evidenced in all programs. The organizations have grievance and appeal systems in place that includes required internal grievance processes, appeal processes, and access to the State's Fair Hearing system.	Continue to focus on the implementation of monitoring specific to member choice and verifying the inclusion of members and legal decision makers in the care planning process.

The State Quality Strategy Evaluation		
State Quality Strategies	**Strengths**	**Recommendations**
	These systems also include policies in place that ensure appropriate authority to file, as well as required timeframes to be adhered to.	
Enable Infrastructure for Health Information	Strong systems are maintained and updated by stable and experienced information system departments within each organization. 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.	No recommendations related to this strategy were identified.

Introduction and Overview

This report covers mandatory and optional external quality review (EQR) activities conducted by the external quality review organization (EQRO), MetaStar, Inc., for the fiscal year from July 1, 2023 – June 30, 2024 (FY 23-24).

The following programs are evaluated through this report:

- Family Care (FC);
- Family Care Partnership (FCP); and
- Program of All-Inclusive Care for the Elderly (PACE).

Acronyms and Abbreviations

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

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

As of August 1, 2024, enrollment was as follows:

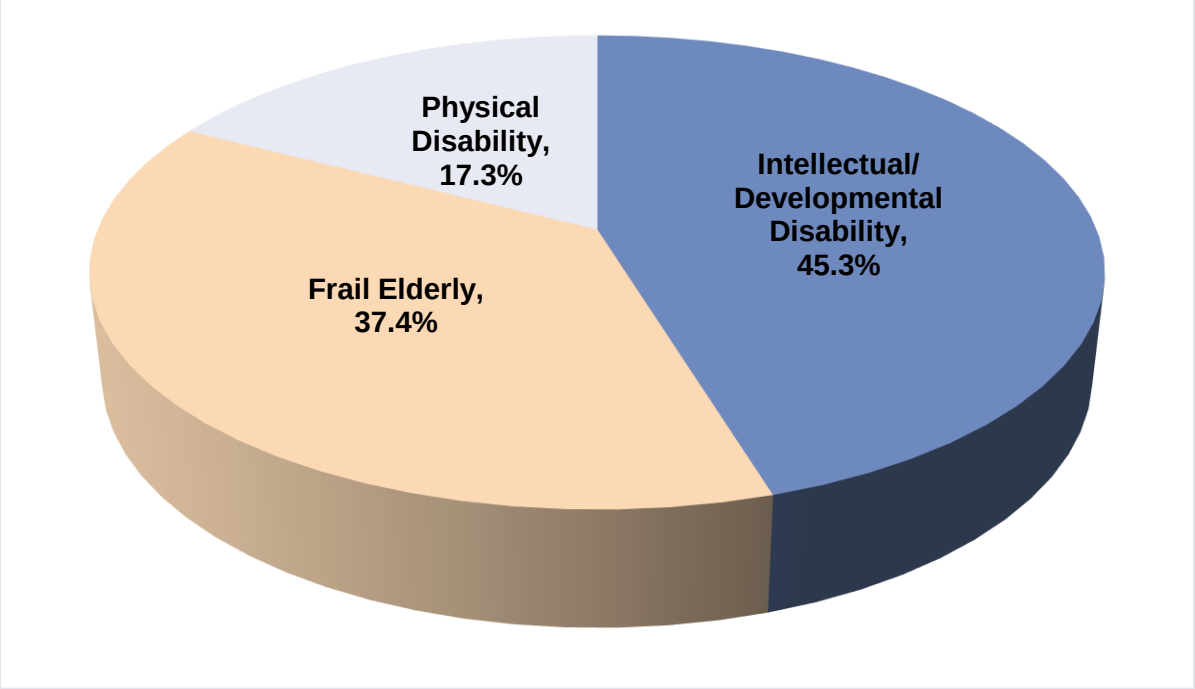
Program	Enrollment
FC	52,731
FCP	3,362
PACE	496

Enrollment for all programs was approximately 56,589. This compares to last year's total enrollment of 55,465 as of August 1, 2023. 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: August 1, 2024



The table below identifies the programs each organization 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, Inc. (MCW)	FC; FCP

Prior to the start of FY 23-24, *i*Care, a subsidiary of Humana, Inc., provided Medicaid managed long-term care services through the FCP program only. In 2023, Inclusa, a MCO providing Medicaid long-term care services through the FC program, was acquired by Humana, Inc., which added the FC program to *i*Care's services. The organization is in the process of combining operations for the FC and FCP programs, though for purposes of this report, findings are separated by *i*Care for FCP and Inclusa for FC.

In preparation for the evaluation of the merged organizations in future years, *i*Care did not undergo a care management review, a non-mandatory activity, in FY 23-24. Historically, the Quality Compliance Review (QCR) and Care Management Review (CMR) for *i*Care was

conducted in March. With the acquisition of Inclusa, the organizations will be evaluated as one entity in July and August for both reviews, starting in FY 24-25. This change would have made a CMR in March and again in July for *i*Care, which is less than six months apart and would have overlapping review periods and inadequate time for improvement efforts to be implemented. The decision was made to forgo the CMR in FY 23-24. QCR was conducted as planned, as the standards for review are different in each fiscal year.

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:

Family Care, Family Care Partnership, and PACE: What's New | Wisconsin Department of Health Services.

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

Family Care | Wisconsin Department of Health Services.

Family Care Partnership | Wisconsin Department of Health Services.

PACE: Program of All-Inclusive Care for the Elderly | Wisconsin Department of Health Services.

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. Progress in this section includes any identified improvement and is not limited to the recommendations made by the EQRO in the prior review. 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.

Community Care, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC, FCP, PACE	FC: 13,738 FCP: 675 PACE: 496	6, 8, 9, 10, 11, 12
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Clinical PIP: Diabetic Care* • *Non-Clinical PIP: Electronic Health Records*	**Strengths Identified** – The MCO conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The MCO established a clear, concise, measurable, and answerable aim statement for both projects. – The MCO clearly identified the PIP population in relation to the aim statement for one project. – The MCO used valid and reliable procedures to collect the PIP data and inform its measurements for one project. – The MCO used appropriate techniques to analyze the PIP data and interpret the results for one project. – The MCO selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. The MCO utilized methodology that was likely to demonstrate significant and sustained improvement for one project. **Progress Identified** – The MCO identified time periods with a start and end date for all aim statements. – The MCO ensured aim statements were answerable. – The MCO specified the frequency of data collection. – The MCO ensured the analysis plan corresponded to the data collection plan. – The MCO assessed the statistical significance of initial and repeat measures for all aim statements. – The MCO ensured project results were concise and easily understood. – The MCO conducted statistical testing for each aim with observed improvement. **Recommendations Identified** – Clearly define all inclusion and exclusion criteria.	

Community Care, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC, FCP, PACE	FC: 13,738 FCP: 675 PACE: 496	6, 8, 9, 10, 11, 12
Findings		
	– Include a strategy for inter-rater reliability for data collection. – Capture data on the variables. – Include a process to validate the accuracy and completeness of data generated from the electronic care management system. – Account for any factors that may influence comparability of initial and repeat measures. – Include rationale for selecting improvement strategies. – Implement a process to ensure a consistent methodology for both the baseline and repeat measurement.	
Protocol 2: Validation of Performance Measures	**Strengths Identified** – The FCP and PACE programs demonstrated practices to ensure members receive pneumococcal vaccinations after the age of 65. **Progress Identified** – No progress was identified. **Recommendations Identified** – Amend the vaccination policies and procedures to include acceptable reasons for influenza and pneumococcal vaccine contraindications as specified in the *DHS Technical Definition*, including deferral of the influenza vaccine for those who have moderate or severe Coronavirus Disease-2019 (COVID-19). – Conduct a root cause analysis for the FC influenza and pneumococcal vaccination rates that declined from MY 2022. The influenza vaccination rates declined for a fourth consecutive year in the FC program. Identifying the root cause or causes will allow the MCO to focus improvement efforts. – Continue efforts to increase influenza and pneumococcal vaccination rates.	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	**Strengths Identified** – The MCO has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members.	

Community Care, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC, FCP, PACE	FC: 13,738 FCP: 675 PACE: 496	6, 8, 9, 10, 11, 12
Findings		
	– The MCO demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to a DHS review for grievances and to the State's Fair Hearing system for appeals, when decisions are adverse to the member. **Progress Identified** – The MCO consistently documented attempts to resolve grievances and appeals through internal review, negotiation, and/or mediation. – The MCO improved the timeliness of issuing written notifications to members on decisions to extend the timeframes for appeal resolutions, and appropriately documented if extension requests were initiated by the member. – The MCO updated the appeal policy for PACE to include the timeframe to provide a decision on expedited appeal requests. – The MCO updated the grievance and appeal policies and procedures to include the requirement that no punitive action is taken against a provider who requests or supports a member's request for an appeal or grievance. – The MCO updated the FCP appeal policy to include the timeframe the member has to request a State Fair Hearing. – The MCO updated the FCP appeal policy to include the criteria when a member does not have the right to continue benefits during an appeal or State Fair Hearing. **Recommendations Identified** – Implement specific monitoring for members being afforded choice among covered services and providers, and report findings to the quality management program as required. – Ensure adequate sample sizes for all programs are used for all required monitoring activities. – Ensure the use of the approved templates for all notices, including the *Notice of Adverse Benefit Determination*. – Prioritize internal monitoring and data collection for timeframes and the issuing of *Notice of Adverse Benefit Determinations.*	

<table>
<tr><th colspan="3">Community Care, Inc.</th></tr>
<tr><th>Programs Operated</th><th>FY 23-24 Enrollment by Program</th><th>GSRs</th></tr>
<tr><td>FC, FCP, PACE</td><td>FC: 13,738 FCP: 675 PACE: 496</td><td>6, 8, 9, 10, 11, 12</td></tr>
<tr><th colspan="3">Findings</th></tr>
<tr><td>Protocol 4: Network Adequacy Validation</td><td colspan="2">Strengths Identified
– The MCO demonstrated consistent and reliable data collection procedures for all state standards.
– The MCO demonstrated consistent and reliable network adequacy methods for all state standards and results.
Progress Identified
– The protocol was implemented in FY 23-24; therefore, there is no progress to assess.
Recommendations Identified
– Improve the network of providers in the service types that did not meet the member to provider ratio standard in all counties:
• FC:
○ Mental Health Day Treatment Services (in all settings).
○ Community Support Program.
○ Alcohol and Other Drug Abuse Services.
○ Residential Services: Adult Family Home One – Two beds.
• FCP:
○ Mental Health Day Treatment Services (in all settings).
• PACE:
○ Mental Health Day Treatment Services (in all settings).</td></tr>
<tr><td>Protocol 9: Conducting Focused Studies of Health Care Quality
Sample Sizes:
• FC: 266
• FCP: 197
• PACE: 175</td><td colspan="2">Strengths Identified
– Comprehensive assessment practices were strengths for the organization in the PACE program.
– The organization had strong practices in place for member-centered planning in the PACE program.
– The organization demonstrated strengths related to care coordination in the PACE program.
– The organization demonstrated strengths in assuring health and safety needs of members were satisfied in all programs.
Progress Identified
– The FCP program improved the timeliness of assessments.</td></tr>
</table>

Community Care, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC, FCP, PACE	FC: 13,738 FCP: 675 PACE: 496	6, 8, 9, 10, 11, 12
Findings		
	– The FC program improved the comprehensiveness of member-centered plans (MCPs), by ensuring all services and supports are included for all identified risks and assessed needs. – The FCP program improved practices to update the MCP when a member has a change in condition. – The FCP program improved the rate of issuing notices when indicated. – The FCP program demonstrated improvements in ensuring signatures for essential providers are obtained as required. **Recommendations Identified** – Ensure the FC and FCP programs evaluate the new assessment criteria related to the understanding of individual rights and abuse, neglect, and exploitation as part of comprehensive assessments. – Focus efforts to improve the comprehensiveness of MCPs in the FC and FCP programs by ensuring each assessed member need has a support, such as a caregiver, included on the plan. – Improve the timeliness of MCP reviews in all programs by obtaining signatures from the member or legal decision maker every six months. – Ensure MCPs are updated following a change in member condition in the FC program. – Focus efforts to ensure notices are issued timely and when indicated in all programs. – Improve the distribution of MCPs to self-directed supports caregivers in the FC program. – Prioritize efforts to improve evidence of follow-up in all programs, specifically for member medical appointments, in all programs. – Improve consistency between the *Wisconsin Long Term Care Functional Screen* (LTCFS) and the organization's documentation, especially related to durable medical equipment (DME) for activities of daily living (ADLs), in all programs. – Ensure members are re-screened following the receipt of a new service or support, such as skilled therapy or wound care, in all programs	

Community Care, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC, FCP, PACE	FC: 13,738 FCP: 675 PACE: 496	6, 8, 9, 10, 11, 12
Findings		
Appendix A: Information Systems Capabilities Assessments	**Strengths Identified** - The organization has a strong system, that is maintained and updated by a stable and experienced information system department. – The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes. – The organization's security systems meet or exceed most industry standards, ensuring consistent system and data availability. – The organization's processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter and performance measurement data and performance measures are provided to the state. **Progress Identified** – The prior review did not identify any recommendations that the organization needed to address. **Recommendations Identified** – The organization satisfied all requirements of the review.	

Inclusa, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC	FC: 16,827	1, 2, 3, 4, 5, 6, 9,10,13,14
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Clinical PIP: Controlling Blood Pressure* *Non-Clinical PIP: Health Equity*	**Strengths Identified** – The MCO conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The MCO established a clear, concise, measurable, and answerable aim statement for both projects. – The MCO clearly identified the PIP population in relation to the aim statement for both projects.	

Inclusa, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC	FC: 16,827	1, 2, 3, 4, 5, 6, 9,10,13,14
Findings		
	– The MCO selected PIP variables and performance measures that were clear indicators of performance for both projects. – The MCO used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The MCO used appropriate techniques to analyze the PIP data and interpret the results for both projects. – The MCO selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. – The MCO utilized methodology that was likely to demonstrate significant and sustained improvement for both projects. **Progress Identified** – The MCO identified time periods with a start and end date for all aim statements. – The MCO ensured aim statements were measurable. – The MCO clearly defined all inclusion and exclusion criteria for the study population. – The MCO described the process utilized to confirm all eligible members are included in the study population. – The MCO specified the frequency of data collection. – The MCO identified all data collection methods. – The MCO ensured the analysis plan corresponded to the data collection plan. – The MCO ensured data analysis plans were established for all project aims. – The MCO compared project results with other entities and/or subgroups. **Recommendations Identified** – Ensure reports build on findings from the data analysis and include interpretation of PIP results, including the extent to which the improvement strategies were successful.	

Inclusa, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC	FC: 16,827	1, 2, 3, 4, 5, 6, 9,10,13,14
Findings		
Protocol 2: Validation of Performance Measures	**Strengths Identified** – The MCO demonstrated practices to ensure members receive pneumococcal vaccinations after the age of 65. **Progress Identified** – The MCO's pneumococcal vaccination rates demonstrated statistically significant improvement in MY 2023 from MY 2022. **Recommendations Identified** – Continue efforts to increase influenza and pneumococcal vaccination rates.	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	**Strengths Identified** – The MCO has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members. – The MCO demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to a DHS review for grievances and to the State's Fair Hearing system for appeals, when decisions are adverse to the member. – The MCO system for monitoring and evaluating the utilization data for services is accessible to all levels of the organization. The access to this data by all levels of the organization is unique to this MCO and has been identified as a best practice. **Progress Identified** – The MCO updated written guidance to include the requirement that financial eligibility decisions and cost share calculations can only be contested through the State Fair Hearing process, and cannot be reviewed by the MCO's internal appeal system. – The MCO updated written guidance and letter template language for instances when a request for an expedited resolution is denied to include the member's right to file a grievance if the member disagrees with the decision.	

Inclusa, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC	FC: 16,827	1, 2, 3, 4, 5, 6, 9,10,13,14
Findings		
	Recommendations Identified – Ensure *Notices of Adverse Benefit Determination* are issued when indicated.	
Protocol 4: Network Adequacy Validation	**Strengths Identified** – The MCO demonstrated consistent and reliable data collection procedures for all state standards. – The MCO demonstrated consistent and reliable network adequacy methods for all state standards and results. **Progress Identified** – The protocol was implemented in FY 23-24; therefore, there is no progress to assess. **Recommendations Identified** – Improve the network of providers in the service types that did not meet the member to provider ratio standard in all counties: • Supported Employment - Small Group Employment Support. • Occupational Therapy. • Speech and Language Pathology Services (except in inpatient and hospital settings). • Prevocational Services.	
Protocol 9: Conducting Focused Studies of Health Care Quality *Sample Size* *FC: 267*	**Strengths Identified** – The MCO demonstrated strengths in assuring health and safety needs of members were satisfied. **Progress Identified** – No progress was identified. **Recommendations Identified** – Improve comprehensiveness of assessments through fully implementing the new assessment criteria. – Focus efforts to ensure each assessed need has a support identified on the MCP.	

Inclusa, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC	FC: 16,827	1, 2, 3, 4, 5, 6, 9,10,13,14
Findings		
	– Review MCPs timely with the member or legal decision maker. – Reassess members for potential changes in condition following significant events, such as hospitalization or emergency room visits. – Ensure *Notices of Adverse Benefit Determination* are issued when indicated. – Obtain signatures for all essential providers. – Improve follow-up to ensure services and supports are received, effective, and satisfactory. – Ensure contact with members is completed as required. – Conduct a root cause analysis to identify a successful approach to improving consistency between the LTCFS and the organization's documentation. – Rescreen members when changes in condition occur.	
Appendix A: Information Systems Capabilities Assessment	**Strengths Identified** - The organization has a strong system, that is maintained and updated by a stable and experienced information system department. – The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes. – The organization's security systems meet or exceed most industry standards, ensuring consistent system and data availability. – The organization's processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter and performance measurement data and performance measures are provided to the state. **Progress Identified** – The prior review did not identify any recommendations that the organization needed to address. **Recommendations Identified** – The organization satisfied all requirements of the review.	

Independent Care Health Plan		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FCP	FCP: 1,490	3, 8, 11,12
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Clinical PIP: Falls Risk* • *Non-Clinical PIP: Behavioral Support*	**Strengths Identified** – The MCO conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The MCO established a clear, concise, measurable, and answerable aim statement for one project. – The MCO clearly identified the PIP population in relation to the aim statement for both projects. – The MCO selected PIP variables and performance measures that were clear indicators of performance for both projects. – The MCO used valid and reliable procedures to collect the PIP data and inform its measurements for one project. – The MCO used appropriate techniques to analyze the PIP data and interpret the results for one project. – The MCO selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. The MCO utilized methodology that was likely to demonstrate significant and sustained improvement for one project. **Progress Identified** – The aim statements included specified time periods for the projects. – The aim statements were answerable. – Inclusion and exclusion criteria for the study population were specified for the projects. – The projects included a comparison of results across multiple entities, such as different member subgroups, provider sites, or other MCOs. – The same methodology was used to calculate the baseline and repeat measures.	

Independent Care Health Plan		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FCP	FCP: 1,490	3, 8, 11,12
Findings		
	Recommendations Identified – Ensure the focus and basic framework of the project aligns with the aim statement. – Summarize the components of the aim statement into a concise, brief statement. – Document the process to validate the accuracy and completeness of data generated from the electronic care management system. – Present results and findings in a concise and easily understood manner. – Document the results of continuous cycles of improvement. – Continue to build a methodologically sound performance improvement project to ensure quantitative improvement is demonstrated from baseline to repeat rates. – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care.	
Protocol 2: Validation of Performance Measures	**Strengths Identified** – No strengths were identified. **Progress Identified** – The MCO's pneumococcal vaccination rate demonstrated statistically significant improvement in MY 2023 from MY 2022. **Recommendations Identified** – Amend the MCO vaccination policies and procedures to include acceptable reasons for influenza and pneumococcal vaccine contraindications as specified in the *DHS Technical Definition*, including deferral of the influenza vaccine for those who have moderate or severe COVID-19. – Continue efforts to increase influenza and pneumococcal vaccination rates. – 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 LTCFS in early 2017.	

Independent Care Health Plan		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FCP	FCP: 1,490	3, 8, 11,12
Findings		
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	**Strengths Identified** – The MCO demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the MCO, including access to a DHS review for grievances and to the State's Fair Hearing system for appeals, when decisions are adverse to the member. **Progress Identified** – The MCO implemented internal file review monitoring to include members being afforded choice among covered services and providers. – The MCO implemented a process to ensure grievances not resolved to the members' satisfaction are being heard by the managed care organization's local grievance and appeal committee. **Recommendations Identified** – Ensure long-term care providers have a means to participate in the quality management program. – Include monitoring of member satisfaction survey results and the quality of subcontractors in the quality management program. – Focus efforts on monitoring to include when a request is made but not identified as a request.	
Protocol 4: Network Adequacy Validation	**Strengths Identified** – The MCO demonstrated consistent and reliable data collection procedures for all state standards. – The MCO demonstrated consistent and reliable network adequacy methods for all state standards and results **Progress Identified** – The protocol was implemented in FY 23-24; therefore, there is no progress to assess. **Recommendations Identified** – Improve the network of providers in the service types that did not meet the member to provider ratio standard in all counties: • Adult Residential Care - Residential Care Apartment Complex.	

Independent Care Health Plan		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FCP	FCP: 1,490	3, 8, 11,12
Findings		
	• Transportation (excluding Ambulance). • Alcohol and Other Drug Abuse (AODA) Day Treatment. • Counseling and Therapeutic Resources. • Prevocational Services. • Supported Employment - Small Group Employment Support.	
Protocol 9: Conducting Focused Studies of Health Care Quality *Sample Size* • *FCP: N/A*	Not applicable. No review conducted due to merging operations of *i*Care and Inclusa.	
Appendix A: Information Systems Capabilities Assessment	Not applicable. Reviewed in FY 22-23.	

Lakeland Care, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC	FC: 7,169	4, 9, 10,13
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Clinical PIP: Chronic Heart Failure* • *Non-Clinical PIP: Member Satisfaction*	**Strengths Identified** – The MCO 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 MCO clearly identified the PIP population in relation to the aim statement for both projects. – The MCO used valid and reliable procedures to collect the PIP data and inform its measurements for both projects.	

Lakeland Care, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC	FC: 7,169	4, 9, 10,13
Findings		
	– The MCO used appropriate techniques to analyze the PIP data and interpret the results for both projects. – The MCO selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. **Progress Identified** – The MCO included the specific measures or results that were tested for statistical significance. **Recommendations Identified** – Ensure the PIP variables are consistent with the aim statement. – Develop and implement a process to ensure a consistent methodology for both the baseline and repeat measurement. – Use consistent methodology for baseline and repeat measures to demonstrate methodologically sound improvement. – Use consistent methodology to calculate baseline and repeat measures to assess the effectiveness of improvement strategies. – Use consistent methodology to calculate baseline and repeat measures to assess statistical evidence that improvements are the results of the interventions.	
Protocol 2: Validation of Performance Measures	**Strengths Identified** – No strengths were identified. **Progress Identified** – No progress was identified. **Recommendations Identified** – Update the policy precautions to include consideration for deferral of an influenza or pneumococcal vaccination when asymptomatic, mild, or moderate COVID-19 symptoms occur. – Update the policy to include instruction that influenza vaccines given concomitantly with a COVID-19 vaccination should be given in different limbs if possible.	

Lakeland Care, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC	FC: 7,169	4, 9, 10,13
Findings		
	– Continue to develop improvement strategies to increase the influenza vaccination rate. – Continue to develop improvement strategies to increase the pneumococcal vaccination rate.	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	**Strengths Identified** – The MCO has a quality management program that documents and monitors required activities, with the purpose of improving the access, timeliness, and quality of supports to members. – The MCO demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the organization, including access to a DHS review for grievances and to the State's Fair Hearing system for appeals, when decisions are adverse to the member. – The MCO's acknowledgement letters for appeals includes information regarding the steps the organization will take to attempt to resolve an issue. Including this list of steps that will be taken to resolve an issue is unique to this MCO, and has been identified as a best practice. **Progress Identified** – No progress was identified. **Recommendations Identified** – Include the specific monitoring mechanisms used for members being afforded choice among covered services and providers into the quality work plan, and ensure this data is reported as required. – Continue efforts to improve the timely issuance of notices when indicated. – Develop systems to identify and track when an extension of an appeal or grievance is organization driven, and to ensure written notice for these extensions are issued within two calendar days.	
Protocol 4: Network Adequacy Validation	**Strengths Identified** – The MCO demonstrated consistent and reliable data collection procedures for all state standards.	

Lakeland Care, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC	FC: 7,169	4, 9, 10,13
Findings		
	– The MCO demonstrated consistent and reliable network adequacy methods for all state standards and results **Progress Identified** – The protocol was implemented in FY 23-24; therefore, there is no progress to assess. **Recommendations Identified** – Improve the network of providers in the service types that did not meet the member to provider ratio standard in all counties: • The Community Support Program. • Alcohol and Other Drug Abuse (AODA) Day Treatment. • Supported employment – Small Group Employment Support. – Ensure locations of services in the provider directory and provider extract match.	
Protocol 9: Conducting Focused Studies of Health Care Quality *Sample Size* *FC: 260*	**Strengths Identified** – Comprehensive assessment practices were strengths for the organization. – The organization demonstrated strengths in assuring health and safety needs of members were satisfied. **Progress Identified** – No progress was identified. **Recommendations Identified** – Focus efforts to ensure each assessed need has a support identified on the MCP. – Update MCPs following changes in members' condition. – Ensure *Notices of Adverse Benefit Determination* are issued when indicated. – Focus efforts on conducting follow-up activities to ensure services and supports are received, effective, and satisfactory. – Conduct a root cause analysis to identify a successful approach to improving consistency between the LTCFS and the organization's documentation.	

Lakeland Care, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC	FC: 7,169	4, 9, 10,13
Findings		
	– Rescreen members when changes in condition occur.	
Appendix A: Information Systems Capabilities Assessment	Not applicable. Reviewed in FY 21 - 22.	

My Choice Wisconsin, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC, FCP	FC: 14,997 FCP: 1,197	1, 2, 3, 5, 6, 8, 9, 11, 12, 13, 14
Findings		
Protocol 1: Validation of Performance Improvement Projects • *Clinical PIP: Hypertension and Diabetes* • *Non-Clinical PIP: Caregiver Strain*	**Strengths Identified** – The MCO conducted and reported detailed research regarding the topic selection and its importance to members for both projects. – The MCO established a clear, concise, measurable, and answerable aim statement for both projects. – The MCO clearly identified the PIP population in relation to the aim statement for both projects. – The MCO selected PIP variables and performance measures that were clear indicators of performance for both projects. – The MCO used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. – The MCO used appropriate techniques to analyze the PIP data and interpret the results for one project. – The MCO selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for one project. – The MCO utilized methodology that was likely to demonstrate significant and sustained improvement for one project.	

My Choice Wisconsin, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC, FCP	FC: 14,997 FCP: 1,197	1, 2, 3, 5, 6, 8, 9, 11, 12, 13, 14
Findings		
	Progress Identified – The aim statements included specific time periods for the projects to be conducted. – The project populations were clearly identified and consistent with the aim statement. – The projects included variables that were adequate to answer the study questions. **Recommendations Identified** – Ensure aim statements are concise and do not include extraneous information that could detract from the focus of the project. – Ensure analysis focuses on the current project and findings are clearly connected to the aim. – Include assessment of the effectiveness of the improvement strategies and identify potential follow-up activities. – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care. – Continue to implement methodologically sound projects to achieve intended results.	
Protocol 2: Validation of Performance Measures	**Strengths Identified** The MCO demonstrated practices to ensure members receive pneumococcal vaccinations after the age of 65. **Progress Identified** – No progress was identified. **Recommendations Identified** – Update the policy to include instruction that influenza vaccines given concomitantly with a COVID-2019 vaccination should be given in different limbs if possible. – Perform barrier and root cause analyses to determine the reasons influenza vaccination rates continue to decline year over year.	

My Choice Wisconsin, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC, FCP	FC: 14,997 FCP: 1,197	1, 2, 3, 5, 6, 8, 9, 11, 12, 13, 14
Findings		
	– Continue to develop improvement strategies to increase the influenza vaccination rate.	
Protocol 3: Compliance with Managed Care Regulations, Quality Compliance Review	**Strengths Identified** – The MCO demonstrated the implementation of a grievance system that provides members with the ability to grieve or appeal actions of the MCO, including access to a DHS review for grievances and to the State's Fair Hearing system for appeals, when decisions are adverse to the member. **Progress Identified** – The MCO implemented specific monitoring for the quality of care management to include members being afforded choice among covered services and providers. – The MCO's appeal process requirements were consistent in all appeal and grievance policies. – The organization implemented a systematic approach to informal resolutions attempts of member appeals and grievances. **Recommendations Identified** – Focus efforts for FCP members to participate in the Member Advisory Committee. – Ensure adequate sampling methodology is used for all required care management monitoring activities in the FCP program. – Ensure use of current DHS and CMS letter templates for notices of covered and non-covered benefits. – Focus efforts on improving the timeliness of issuing a *Notice of Adverse Benefit Determination* when indicated. – Develop and implement a process to ensure the written acknowledgement for each grievance is issued.	
Protocol 4: Network Adequacy Validation	**Strengths Identified** – The MCO demonstrated consistent and reliable data collection procedures for all state standards. – The MCO demonstrated consistent and reliable network adequacy methods for all state standards and results	

<table>
<tr><th colspan="3">My Choice Wisconsin, Inc.</th></tr>
<tr><th>Programs Operated</th><th>FY 23-24 Enrollment by Program</th><th>GSRs</th></tr>
<tr><td>FC, FCP</td><td>FC: 14,997 FCP: 1,197</td><td>1, 2, 3, 5, 6, 8, 9, 11, 12, 13, 14</td></tr>
<tr><th colspan="3">Findings</th></tr>
<tr><td></td><td colspan="2">Progress Identified
– The protocol was implemented in FY 23-24; therefore, there is no progress to assess.
Recommendations Identified
– Improve the network of providers in the service types that did not meet the member to provider ratio standard in all counties:
• FC:
○ Transportation (excluding ambulance).
○ Transportation (specialized transportation) – Other Transportation.
○ Adult Residential Care – Residential Care Apartment Complex.
• FCP:
○ Transportation (specialized transportation) – Other Transportation.
– Ensure locations of services in the provider directory and provider extract match for both programs.</td></tr>
<tr><td>Protocol 9: Conducting Focused Studies of Health Care Quality
Sample Sizes
• FC: 264
• FCP: 222</td><td colspan="2">Strengths Identified
– Comprehensive assessment practices were strengths for the organization.
– The organization demonstrated strengths in assuring health and safety needs of members were satisfied.
Progress Identified
– The organization improved the timeliness of MCP reviews in the FCP program.
Recommendations Identified
– Focus efforts to improve the comprehensiveness of assessment in the FCP program.
– Ensure MCPs in the FC program include services or supports for all assessed needs.</td></tr>
</table>

My Choice Wisconsin, Inc.		
Programs Operated	**FY 23-24 Enrollment by Program**	**GSRs**
FC, FCP	FC: 14,997 FCP: 1,197	1, 2, 3, 5, 6, 8, 9, 11, 12, 13, 14
Findings		
	– Continue efforts in both programs to improve the timeliness of MCP reviews. – Focus efforts on improving the timeliness of issuing a *Notice of Adverse Benefit Determination* when indicated. – Improve practices for obtaining signatures from essential service providers in both programs. – Evaluate care management practices in both programs related to follow-up to ensure member services are received and satisfactory to improve the completion and timeliness of follow-up activities. – Ensure contacts with members are completed as required in both programs. – Conduct a root cause analysis to determine barriers to achieving consistency between the LTCFS and the organization's documentation. – Improve practices to conduct a rescreen when a member has a change in condition.	
Appendix A: Information Systems Capabilities Assessment	Not applicable. Reviewed in FY 22-23.	

Protocol 1: Validation of Performance Improvement Projects

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

The Department of Health Services (DHS) contractually requires organizations operating 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. Managed Care Organization (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 2023, organizations submitted proposals to DHS in January 2023. DHS directed MCOs to submit final reports by December 30, 2023. MetaStar validated one clinical and one non-clinical PIP for each organization, for a total of 10 PIPs for the following MCOs and programs:

Managed Care Organization	Program(s)
Community Care, Inc. (CCI)	FC; FCP; PACE
Inclusa, Inc. (Inclusa)	FC
Independent Care Health Plan (*i*Care)	FCP

Managed Care Organization	Program(s)
Lakeland Care, Inc. (LCI)	FC
My Choice Wisconsin, Inc. (MCW)	FC; FCP

Overall PIP Results

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

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

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

The validation results from each performance improvement project (PIP) discussed in this report are summarized in the table below.

Two validation ratings are displayed:

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

Fiscal Year (FY) 23 – 24 PIP Results						
MCO	**Program**	**Topic**	**Clinical/Non-Clinical**	**Population**	**Methodology Rating**	**Significant Improvement Rating**
CCI	FC, FCP, PACE	Diabetic Care	Clinical	Adults	High Confidence	High Confidence
CCI	FC, FCP, PACE	Electronic Health Records	Non-Clinical	Adults	Moderate Confidence	Low Confidence
*i*Care	FCP	Falls Risk	Clinical	Adults	Moderate Confidence	No Confidence
*i*Care	FCP	Behavioral Support	Non-Clinical	Adults	High Confidence	Low Confidence
Inclusa	FC	Controlling Blood Pressure	Clinical	Adults	High Confidence	High Confidence
Inclusa	FC	Health Equity	Non-Clinical	Adults	High Confidence	High Confidence
LCI	FC	Chronic Heart Failure	Clinical	Adults	Moderate Confidence	No Confidence
LCI	FC	Member Satisfaction	Non-Clinical	Adults	Moderate Confidence	No Confidence
MCW	FC, FCP	Hypertension and Diabetes	Clinical	Adults	High Confidence	No Confidence
MCW	FC, FCP	Caregiver Strain	Non-Clinical	Adults	High Confidence	No Confidence

Following are the results of MetaStar's evaluation of the clinical and non-clinical PIPs conducted in 2023.

Clinical PIPs

The validation ratings for each clinical PIP project are identified below. The methodology section includes a table listing each standard that was evaluated for the PIP methodology. The

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

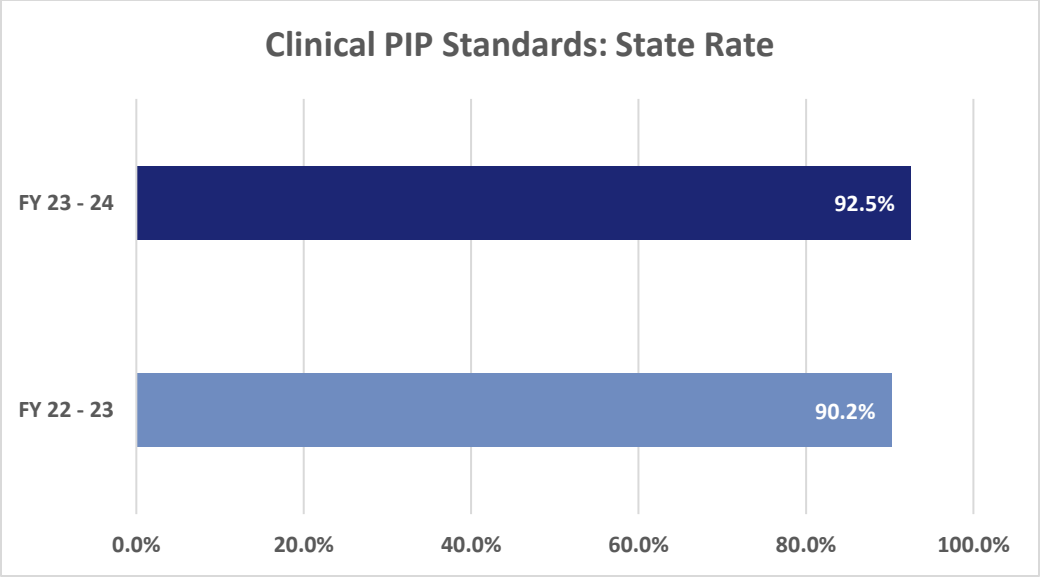
Methodology

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

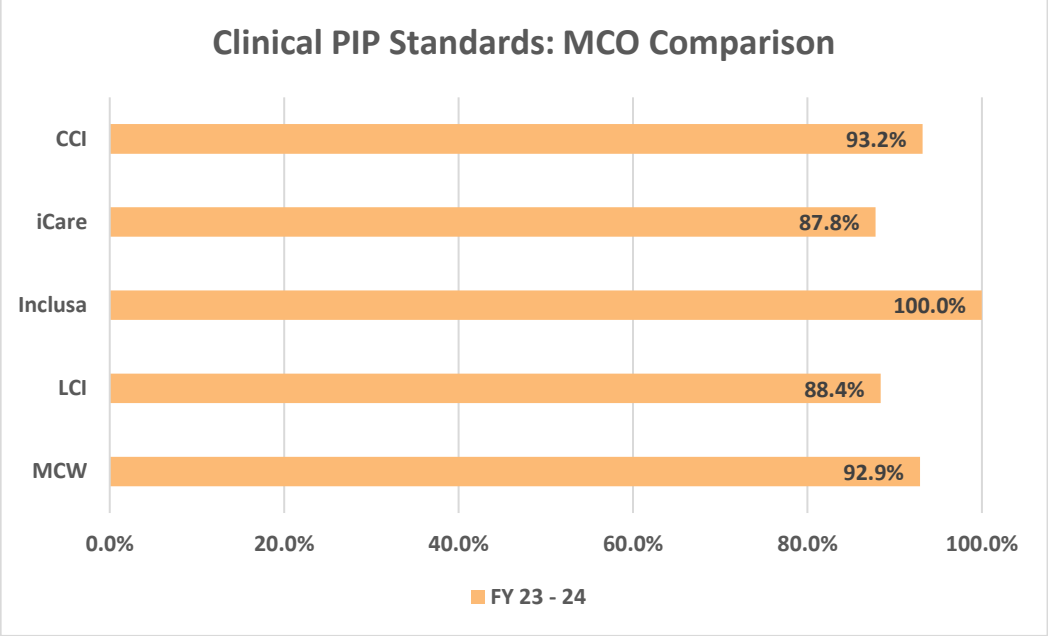
FY 23-24 Methodology Rating – Clinical PIPs			
Standards	**Scoring Elements**	**Percentage**	**Methodology Rating**
Standard 1: PIP Topic	21/21	100.0%	High Confidence
Standard 2: PIP Aim Statement	29/30	96.7%	High Confidence
Standard 3: PIP Population	10/10	100.0%	High Confidence
Standard 4: Sampling Method*	N/A	N/A	N/A
Standard 5: PIP Variables and Performance Measures	29/31	93.5%	High Confidence
Standard 6: Data Collection Procedures	38/40	95.0%	High Confidence
Standard 7: Data Analysis and Interpretation of PIP Results	34/36	94.4%	High Confidence
Standard 8: Improvement Strategies	27/30	90.0%	High Confidence
Standard 9: Significant and Sustained Improvement	10/16	62.5%	No Confidence
Methodology Rating	**198/214**	**92.5%**	**High Confidence**

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

The graph on the next page illustrates the State's overall compliance with these standards in FY 23-24 and compares the score to the same standards reviewed in FY 22-23.



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



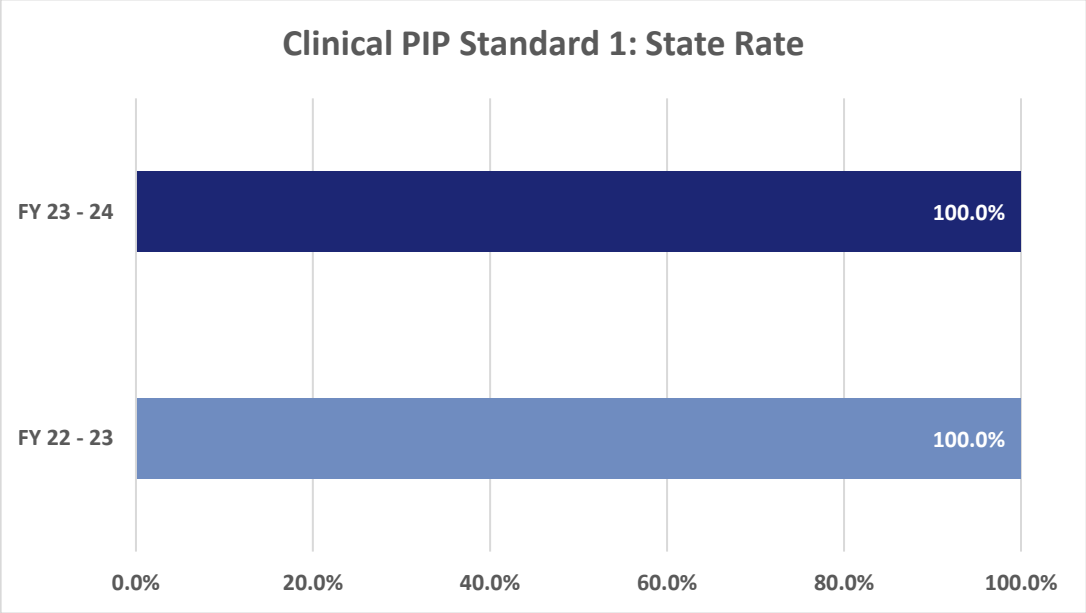
Observation and Analysis: Standard 1. PIP Topic

The MCOs should target improvement in relevant areas of clinical services. The topic selection process should consider the national Quality Strategy, CMS Core Set Measures, and DHS priorities. When appropriate or feasible, enrollee and provider input should be obtained. All

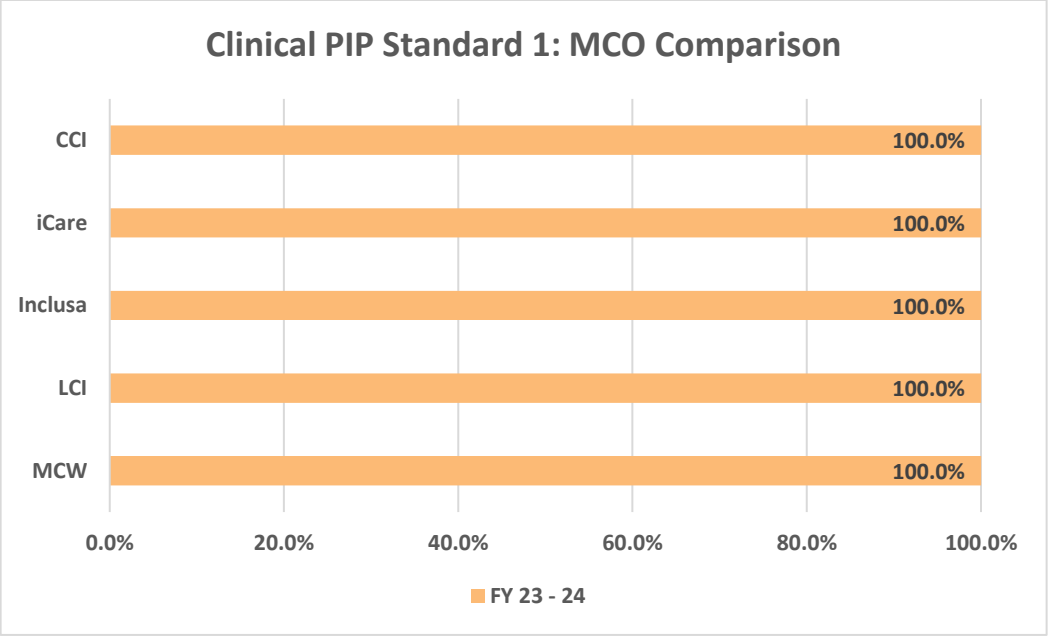
topics should address areas of special populations or high priority services. Standard 1 evaluated each PIP on five possible scoring elements. Collectively, the MCOs satisfied requirements for 21 out of 21 scoring elements, for a score of 100.0 percent.

All clinical topics included an analysis of topic selection and the 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 23-24 and compares the score to the same standard reviewed in FY 22-23.



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 evaluated each PIP on six possible scoring elements. Collectively, the MCOs satisfied requirements for 29 out of 30 scoring elements, for a score of 96.7 percent.

Aim statements for all clinical projects included the required criteria. All but one aim statement was concise.

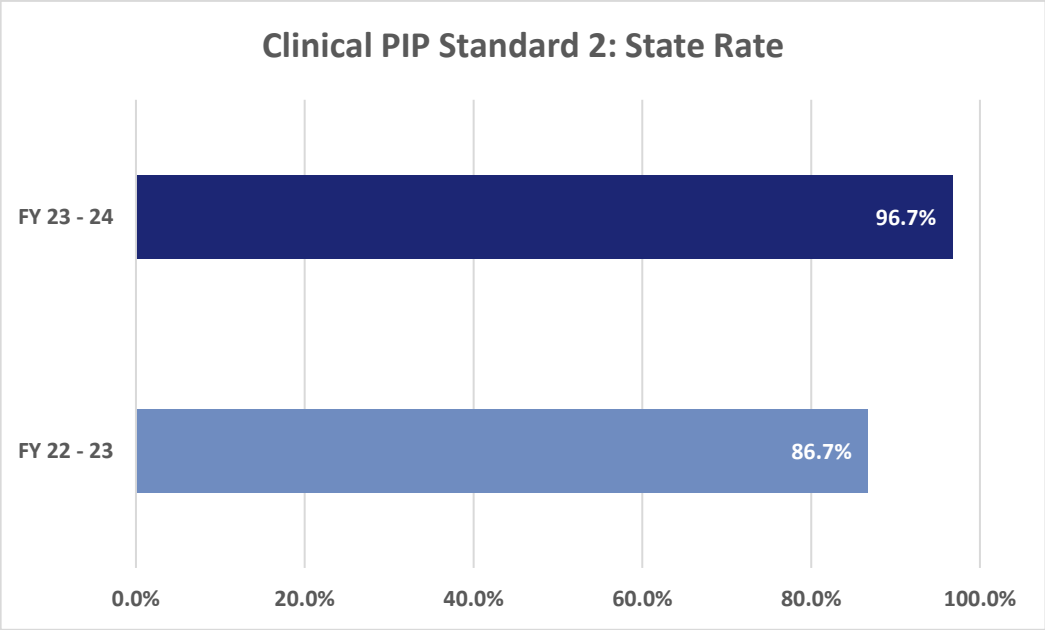
The table below identifies the aim statements for each clinical PIP topic. The aim statements in the table are copied from the PIP reports submitted by the organizations. No adjustments or edits were made by MetaStar.

MCO	Clinical Topics	Aim Statements
CCI	Diabetic Care	"Can targeted education by IDTS on the importance of annual eye exams with members diagnosed with Type 1 or Type 2 diabetes in the pilot teams, increase the compliance of eye exams from 20% to 50% from 04/01/2023 through 11/30/2023?"
*i*Care	Falls Risk	"Can FCP IDT staff reduce the rate of falls in the current FCP population aged 65 and older with an existing diagnosis of Alzheimer's and/or dementia by 10% from 424.1 per 1,000 to a fall rate of 382.1 per 1,000 between 4/1/2023 and 9/30/2023 by

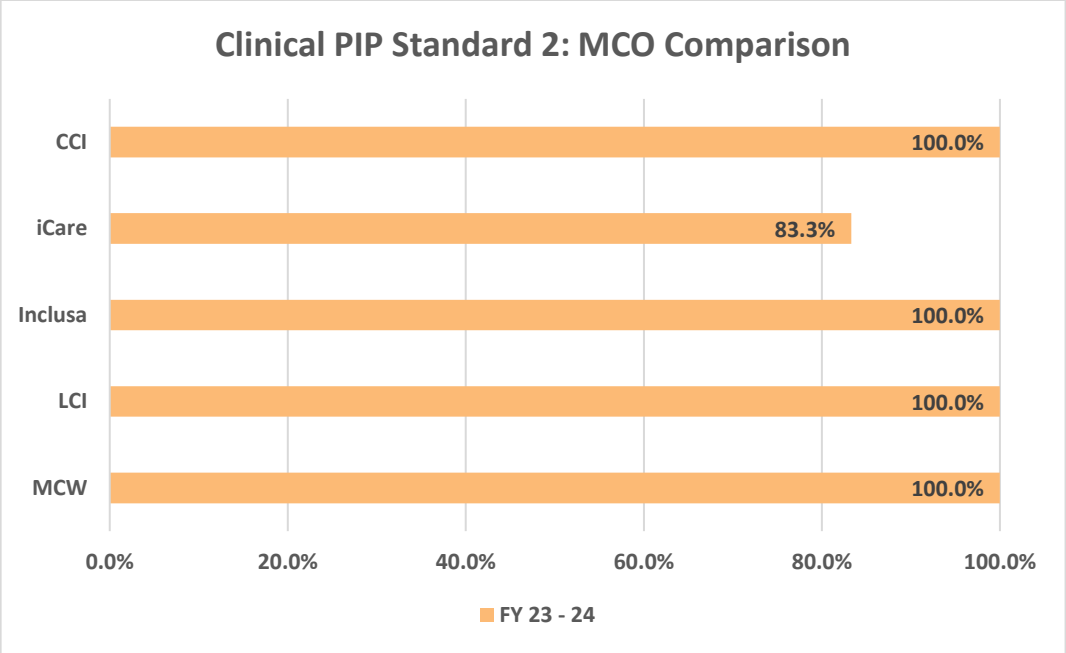
MCO	Clinical Topics	Aim Statements
		implementing enhanced care management strategies, thereby decreasing the disparity in the rate of falls experienced by those members in the study cohort when compared with current FCP members in the same age group without a diagnosis of Alzheimer's and/or dementia."
Inclusa	Controlling Blood Pressure	"Will targeted member assessment and self-monitoring blood pressure program training by the members' care team, increase the percentage of member care plans with interventions specific to addressing the core issue of hypertension, within the non-residential / non-institutional enrolled frail elder members who have a diagnosis of essential hypertension with a blood pressure value in the stage II hypertension range, from 18% as of February 14,2023 (baseline) to 90% by November 1, 2023 (repeat)?"
LCI	Chronic Heart Failure	Aim A: "Does providing education and member resources to Registered Nurse Care Managers (RNCMs) about Congestive Heart Failure (CHF) self-management increase Target Group 1 (LCI members who have a diagnosis of CHF, are not receiving hospice services, are currently prescribed a diuretic medication, and receive care management services from care management staff supervised by Beth Kowalczyk, Lacy Klatt, Stacy Packard, Emily Baumann, Samantha Hoffman, Amy Waterstradt, and Yer Lee) members' documented ongoing treatment or monitoring related to CHF in their member record for comprehensive assessments completed from 25.6% to 30.6% from May 1, 2023 to October 31, 2023?" Aim B: "Does providing education and member resources to Registered Nurse Care Managers (RNCMs) about Congestive Heart Failure (CHF) self-management increase Target Group 2 (LCI members who have a diagnosis of CHF, are not receiving hospice services, are currently prescribed a diuretic medication, and receive care management services from care management staff supervised by Nikki Grandaw, Dawn Klaeser, Sandy Washkuhn, April Scott, and Sarah Ledden) members' documented ongoing treatment or monitoring related to CHF in their member record for comprehensive assessments completed from 24.4% to 29.4% from June 1, 2023 to October 31, 2023?"
MCW	Hypertension and Diabetes	Aim A: "Following the care management training on ACE/ARB Medication Therapy, including the Diabetes CPG, with FC and FCP members with diagnoses of hypertension and diabetes, will the percentage of MCW FC and FCP members with hypertension & diabetes who are prescribed an ACE or ARB Medication Therapy increase from 46.8% (Baseline Measurement Period

MCO	Clinical Topics	Aim Statements
		4/1/2022 - 10/31/2022) to 50%* (Outcome Measurement Period 4/1/2023 - 10/31/2023)?" Aim B: "Will education on and implementation of the Diabetes CPG and ACE/ARB Medication Therapy training with MCW FC and FCP members with hypertension & diabetes decrease the percent of members with 130/80 or higher blood pressure values from 20.2% (Baseline Measurement Period 4/1/2022 – 10/31/2022) to 19.3%** (Outcome Measurement Period 4/1/2023 - 10/31/2023)?"

The graph below illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



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

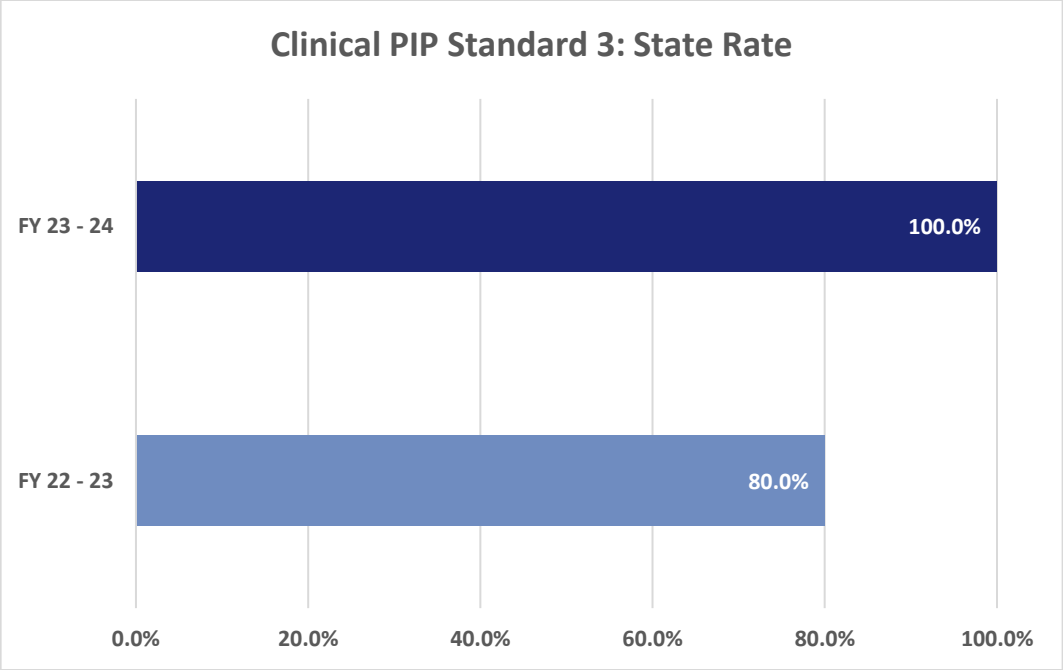


Observation and Analysis: Standard 3. PIP Population

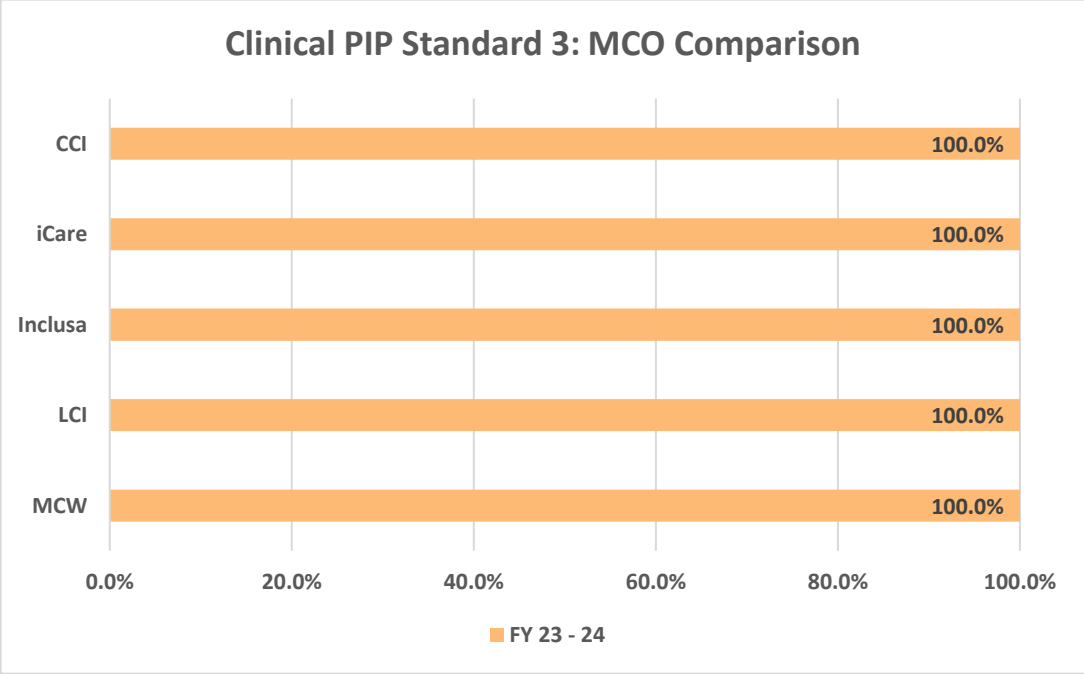
The MCOs must clearly define the project's population, identifying all inclusionary and exclusionary criteria. If the entire eligible MCO population is included in the project, the data collection approach must ensure it captures all applicable members. Standard 3 evaluated each PIP on two possible scoring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

All clinical projects clearly defined the PIP populations related to the aim statements.

The graph on the next page illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



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



Observation and Analysis: Standard 4. Sampling Method

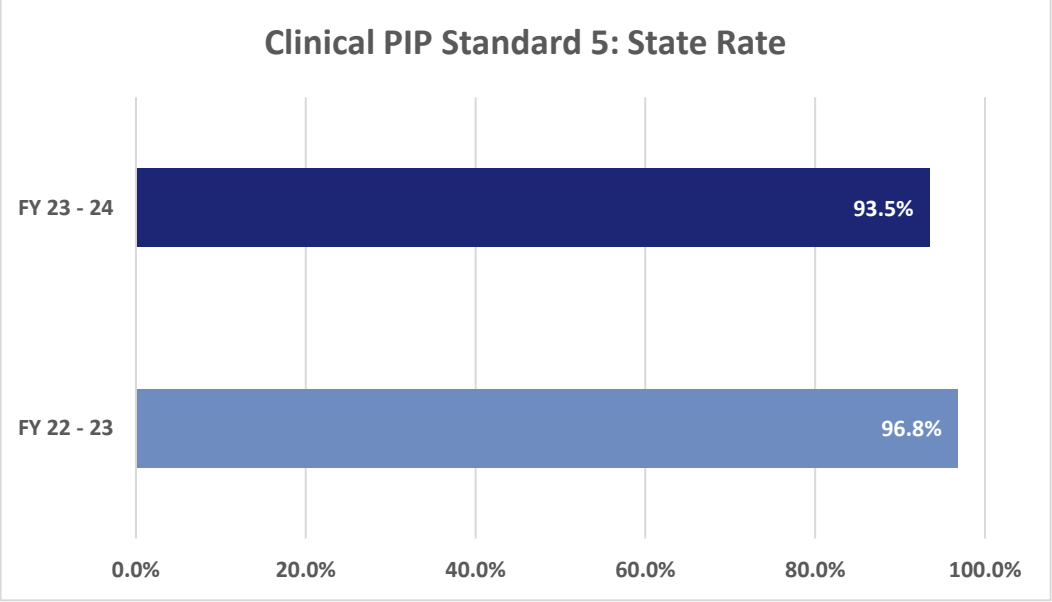
The MCOs must have appropriate sampling methods to ensure data collection produces valid and reliable results. Sampling was not used for any clinical projects in FY 23-24 or FY 22 – 23; therefore, there are no results for this standard to display.

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

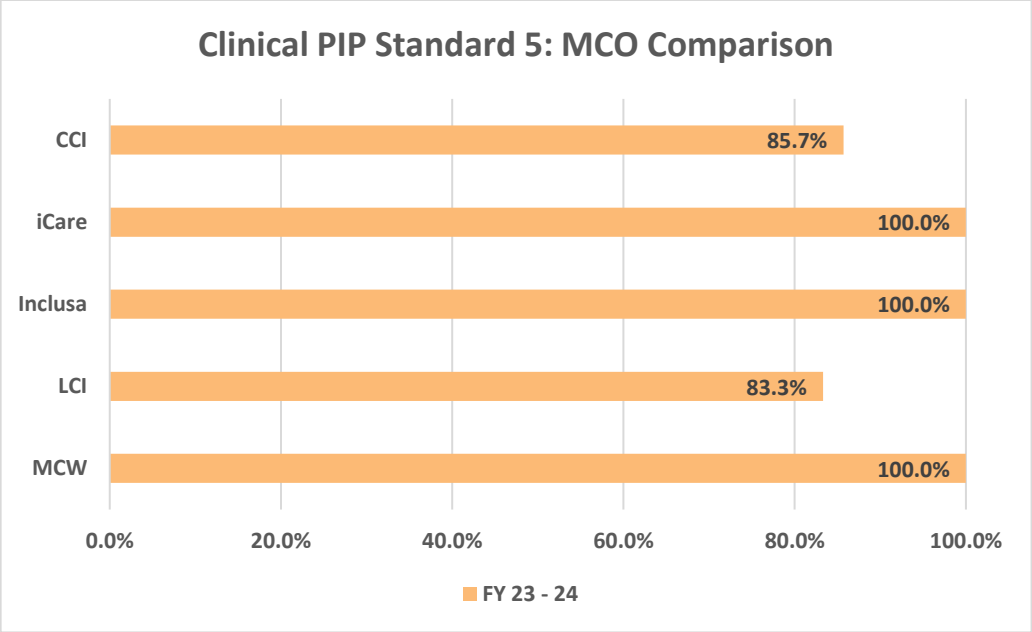
MCOs must select variables that identify the MCO's performance on the PIP questions objectively and reliably, using clearly defined indicators of performance. The PIP should include the number and type of variables that are adequate to answer the PIP question, can measure performance, and can track improvement over time. Standard 5 evaluated each PIP on 10 possible scoring elements. Collectively, the MCOs satisfied requirements for 29 out of 31 scoring elements, for a score of 93.5 percent.

Almost all clinical projects used PIP variables and performance measures that were clear indicators of performance and were adequate to answer the PIP aim statements. All but one project 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 23-24 and compares the score to the same standard reviewed in FY 22-23.



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



Observation and Analysis: Standard 6. Data Collection Procedures

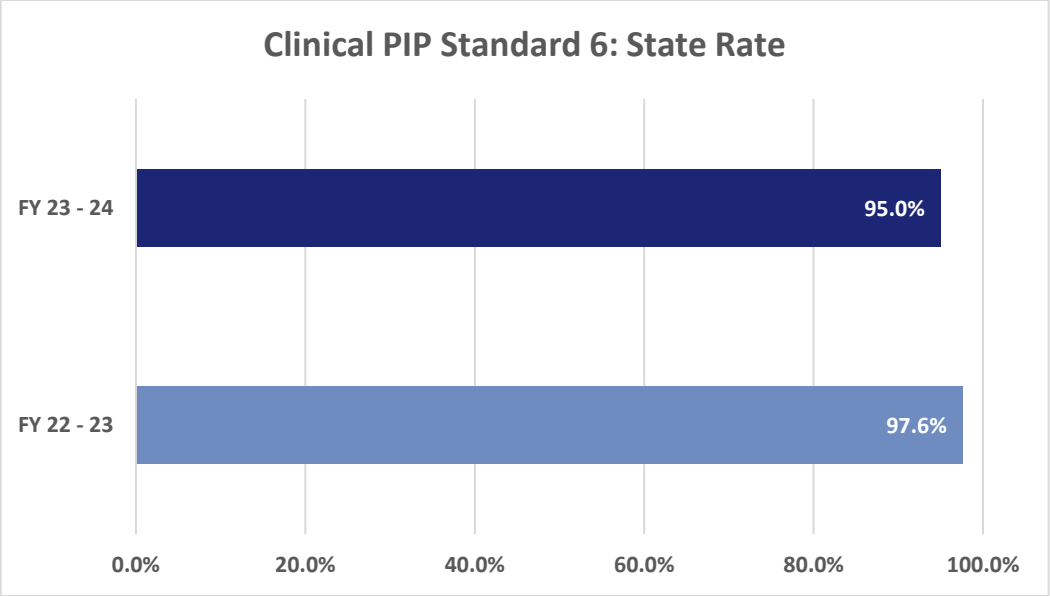
MCOs must establish data collection procedures that ensure valid and reliable data throughout the project. The data collection plan should specify the following:

- 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.

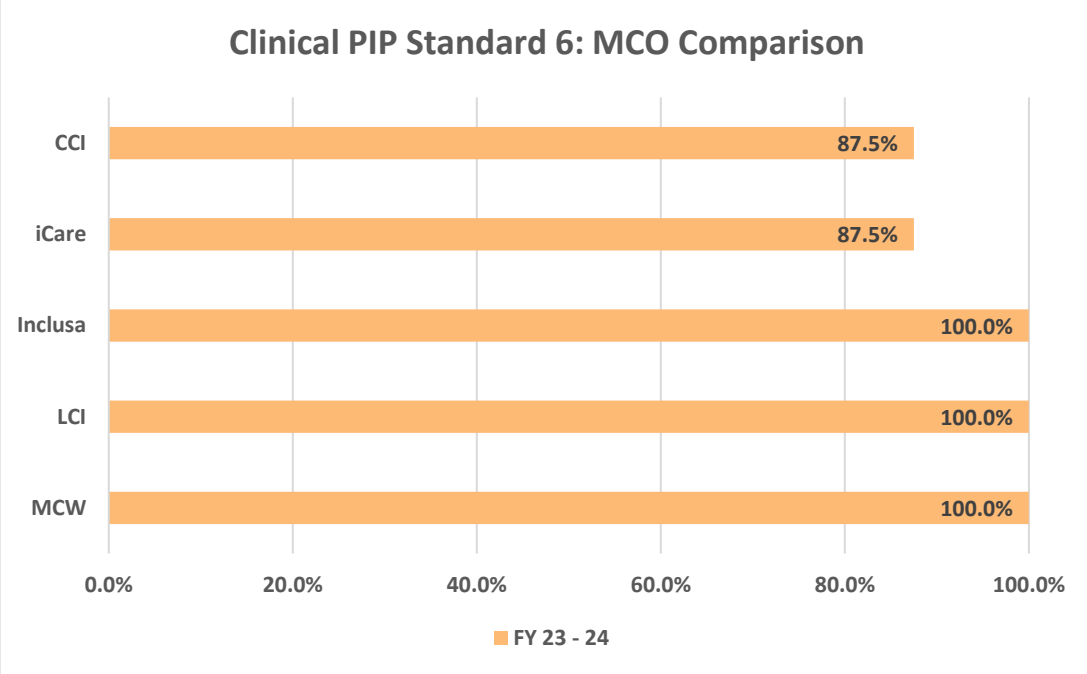
Standard 6 evaluated each PIP on 16 possible scoring elements. Collectively, the MCOs satisfied requirements for 38 out of 40 scoring elements, for a score of 95.0 percent.

All clinical projects detailed data collection process to ensure that appropriate data would be available for the PIPs. Each project clearly defined the data sources and collection methods to be used. The clinical projects for CCI and *i*Care did not include how data obtained from the electronic health record (EHR) would be validated for completeness and accuracy.

The graph on the next page illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



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



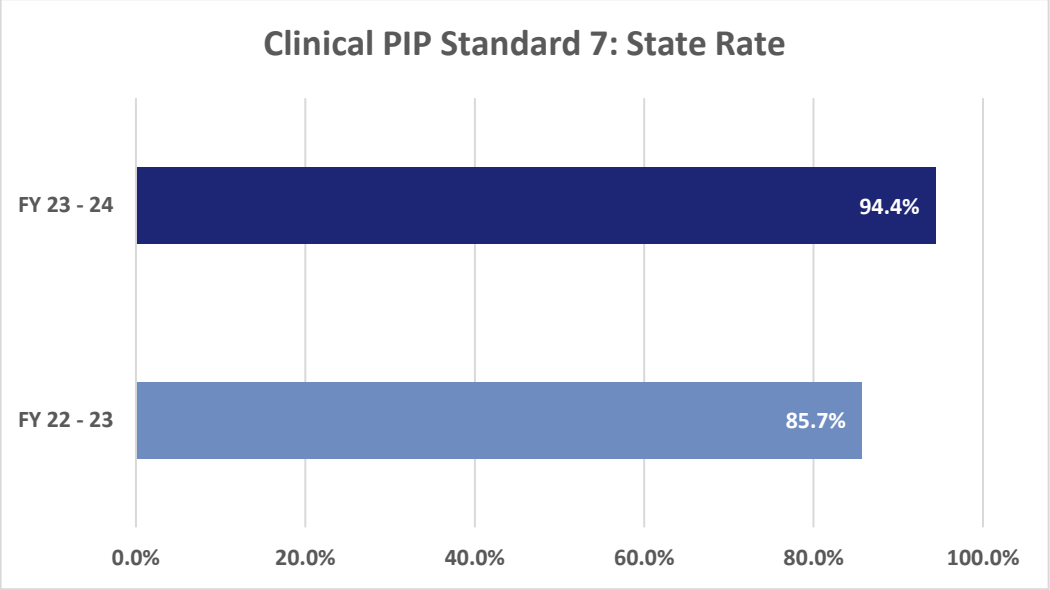
Observation and Analysis: Standard 7. Data Analysis and Interpretation of PIP Results

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

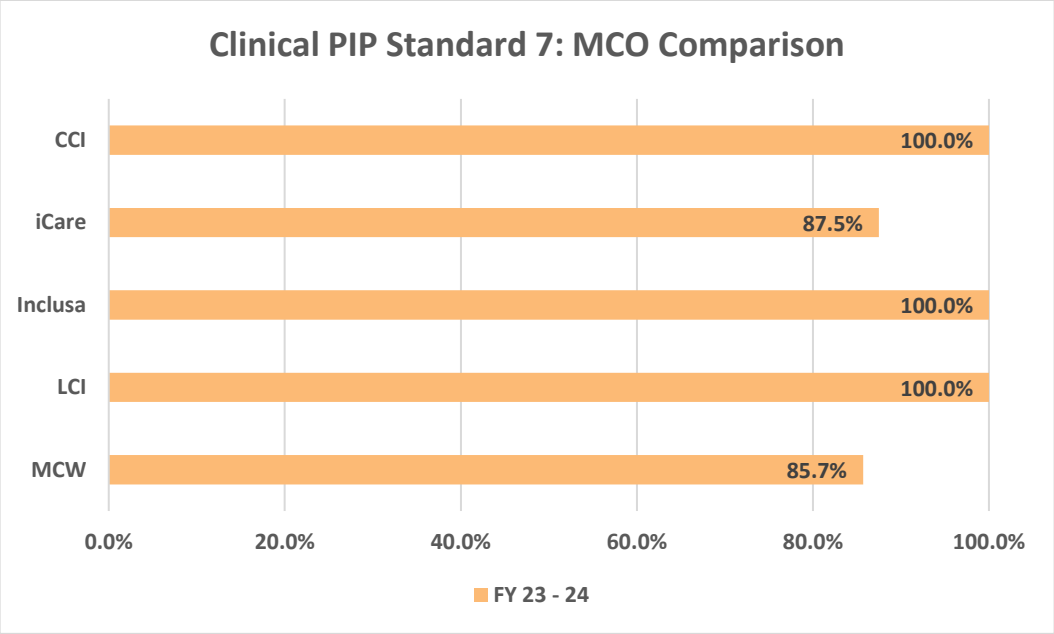
performance is statistically significant. Standard 7 evaluated each PIP on eight possible scoring elements. Collectively, the MCOs satisfied requirements for 34 out of 36 scoring elements, for a score of 94.4 percent.

All clinical PIPs completed the data analysis according to the data analysis plan and contained evidence of statistical assessment to test the change between initial and repeat measurements. All projects also accounted for any factors that may have influenced comparability of results or threatened the validity of findings. The clinical projects for *i*Care and MCW did not present the results in a concise and easily understood manner.

The graph below illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



The graph on the next page 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 evaluated each PIP on six possible scoring elements. Collectively, the MCOs satisfied requirements for 27 out of 30 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 (PDSA) cycles during project implementation and assessed the effectiveness of the improvement strategies. All reports included information on how the project was culturally and linguistically appropriate.

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

Improvement Strategy Effectiveness Ratings	
Effective	MCO indicated the strategy was effective.
Not Effective	MCO indicated the strategy was not effective.

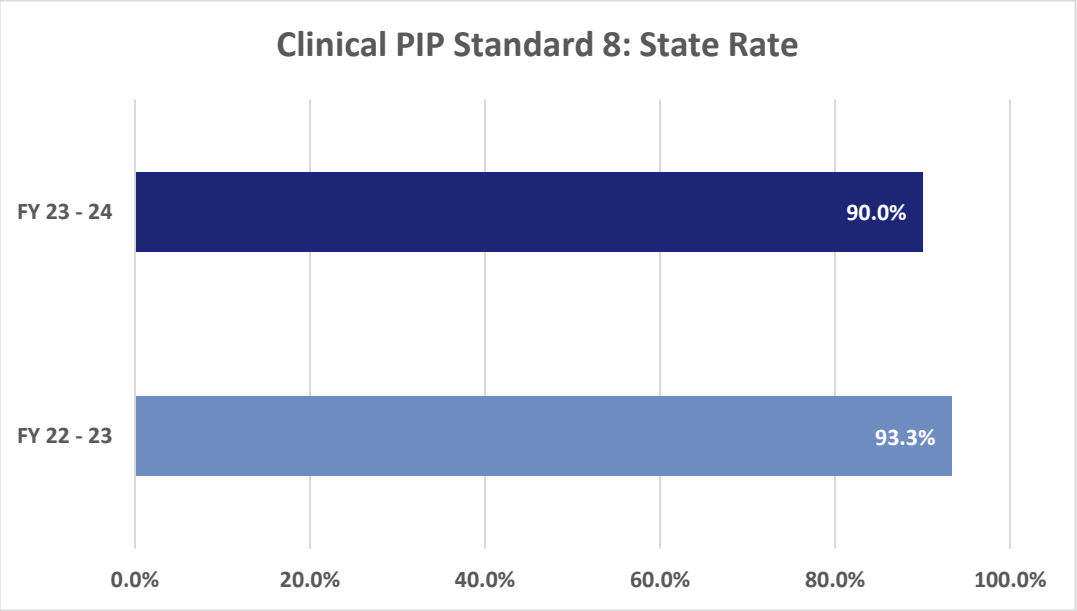
Improvement Strategy Effectiveness Ratings	
No Evaluation	MCO could not determine if the strategy was effective, or there was no evaluation of the effectiveness.
Not Implemented	MCO did not implement the strategy.

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

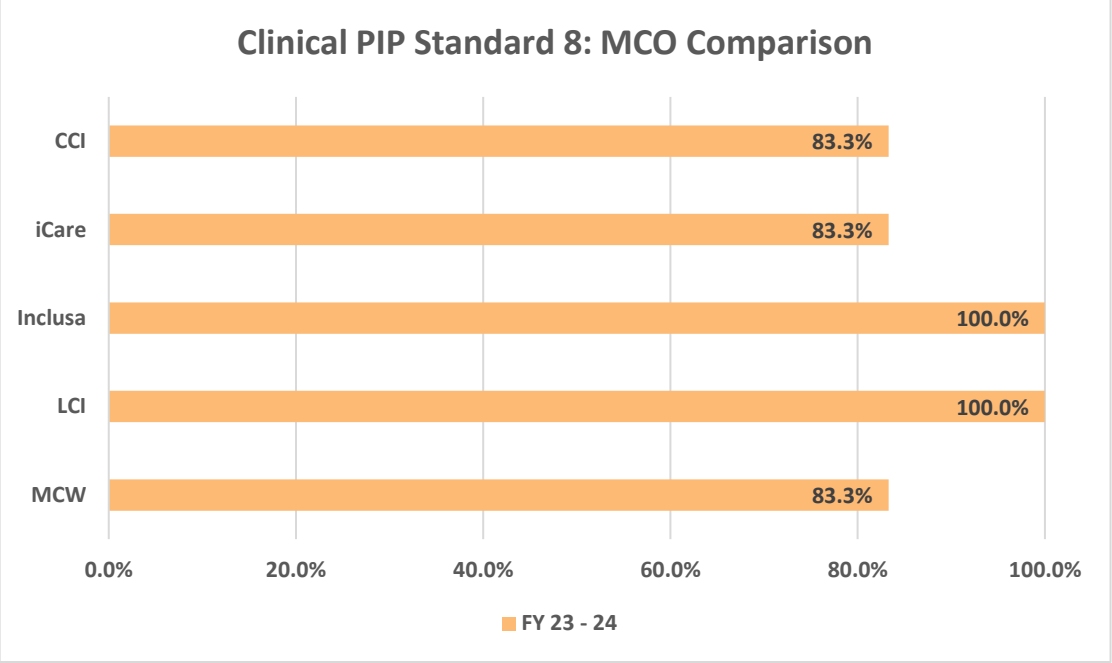
MCO	Topic	Clinical Improvement Strategies	Effectiveness
CCI	Diabetic Care	Directed communication with staff to provide updates or changes to processes.	Effective
*i*Care	Falls Risk	Completed a *Falls Risk Assessment* and *Falls Risk Checklist* after each reported acute fall incident.	Effective*
*i*Care	Falls Risk	Provided enhanced falls risk education to members and guardians.	Effective*
*i*Care	Falls Risk	Conducted interdisciplinary team staff meetings and care conferences after a reported fall.	Effective*
*i*Care	Falls Risk	Completed medication reviews and pharmacy consults.	Effective*
*i*Care	Falls Risk	Completed *Falls Risk Rounds* at monthly nursing meetings.	Effective*
*i*Care	Falls Risk	Included a falls risk outcome on the member-centered plan when a member experienced frequent falls.	Effective*
*i*Care	Falls Risk	Communicated with the member's medical providers after a fall.	Effective*
*i*Care	Falls Risk	Completed ongoing education to interdisciplinary team staff regarding falls.	Effective*
*i*Care	Falls Risk	Followed up with members 45 days after a fall to evaluate the effectiveness of falls interventions.	Effective
Inclusa	Controlling Blood Pressure	Implemented a targeted member assessment.	Effective
Inclusa	Controlling Blood Pressure	Provided self-monitoring blood pressure training to the care team.	Effective
LCI	Chronic Heart Failure	Provided education to the Register Nurse Care Managers to increase their knowledge and use of resources in discussions with members about ongoing treatment and monitoring needs related to the member's Chronic Heart Failure diagnosis.	Effective
MCW	Hypertension and Diabetes	Conducted Care Management Training on Angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs) Medication Therapy.	Effective*
MCW	Hypertension and Diabetes	Implemented a Diabetes Clinical Practice Guideline (CPG).	Effective*

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

The graph below illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



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 10 out of 16 scoring elements, for a score of 62.5 percent.

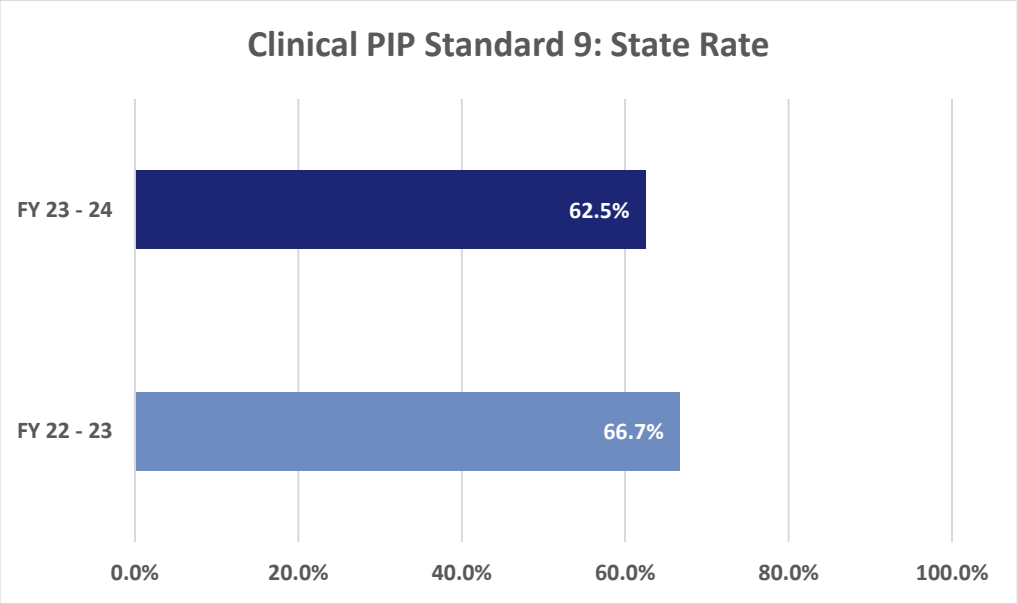
Scoring element 9.1 evaluated using the same methodology for the project's baseline and repeat measurements. The project submitted by LCI did not use the same methodology to calculate each measurement.

Scoring element 9.2 evaluated if there was quantitative evidence of improvement. The clinical projects from two MCOs did not evidence improvement, *i*Care and MCW. In the project submitted by LCI, quantitative evidence could not be determined due to the change in methodology for calculating the baseline and repeat measurements.

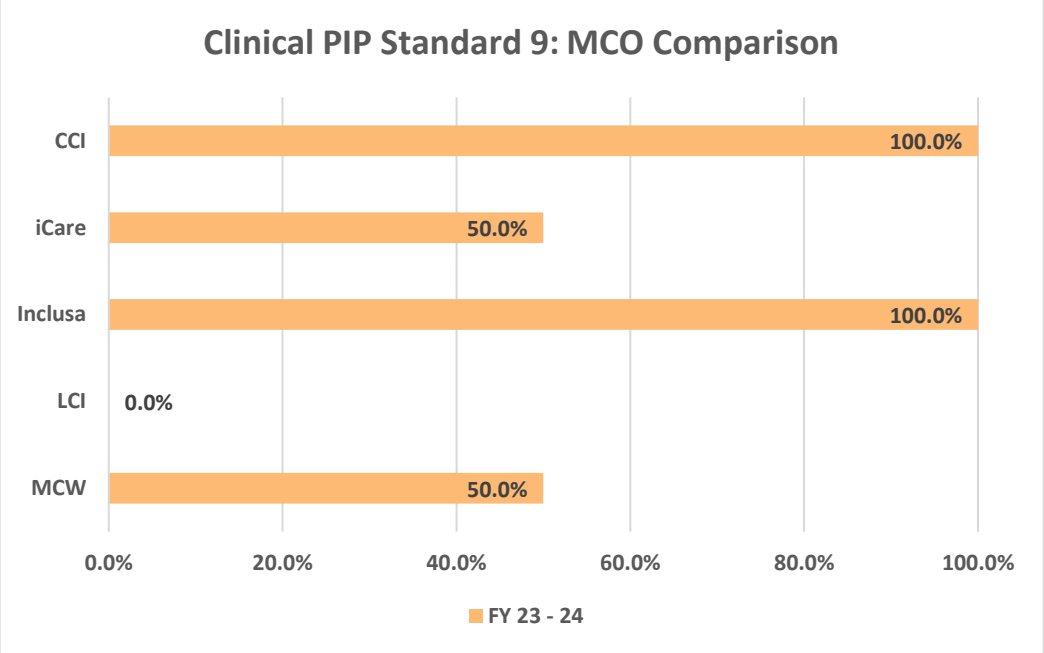
Scoring element 9.3 assessed if the reported improvement in performance was likely to be the result of the selected intervention. This was not able to be evaluated in the LCI project that used different methodology in the baseline and repeat measurement.

Scoring element 9.4 evaluated if there was statistical evidence that the observed improvement was the result of the intervention. Due to the lack of comparability between measures in the LCI PIP, valid statistical testing could not be completed.

The graph on the next page illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



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



Significant Improvement

The significant improvement rating was determined by MetaStar through the use of a statistical test using each project's baseline and repeat measurement for the aim statement. If there are multiple aim statements, testing is completed on each aim and the lowest rating achieved is the

significant improvement rating for the project. Data used by the MCOs to determine baseline and repeat measurements was submitted to MetaStar for the evaluation. The results are outlined below.

MCO	Topic	Baseline Measurement	Repeat Measurement	Significant Improvement Rating
CCI	Diabetic Care	84 of 398 members with completed diabetic eye exams	213 of 417 members with completed diabetic eye exams	High Confidence
*i*Care	Falls Risk	Estimated Fall Rate: 424.1 falls per 1,000 members Study Cohort: 41 falls experienced by 109 members	Estimated Fall Rate: 506.3 falls per 1,000 members Study Cohort: 24 falls experienced by 89 members	No Confidence
Inclusa	Controlling Blood Pressure	28 of 158 members have essential hypertension interventions listed on their care plan	116 of 118 members have essential hypertension interventions listed on their care plan	High Confidence
LCI Aim A	Chronic Heart Failure	41 of 160 members evidenced expected CHF documentation	80 of 139 evidenced expected CHF documentation	High Confidence
LCI Aim B	Chronic Heart Failure	30 of 123 members evidenced expected CHF documentation	43 of 82 members evidenced expected CHF documentation	No Confidence*
MCW Aim A	Hypertension and Diabetes	44 of 94 members on ACE/ARB Medication Therapy	65 of 109 members on ACE/ARB Medication Therapy	Low Confidence
MCW Aim B	Hypertension and Diabetes	94 of 466 members with High Blood Pressure	109 of 598 members with High Blood Pressure	No Confidence

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

Non-Clinical PIPs

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

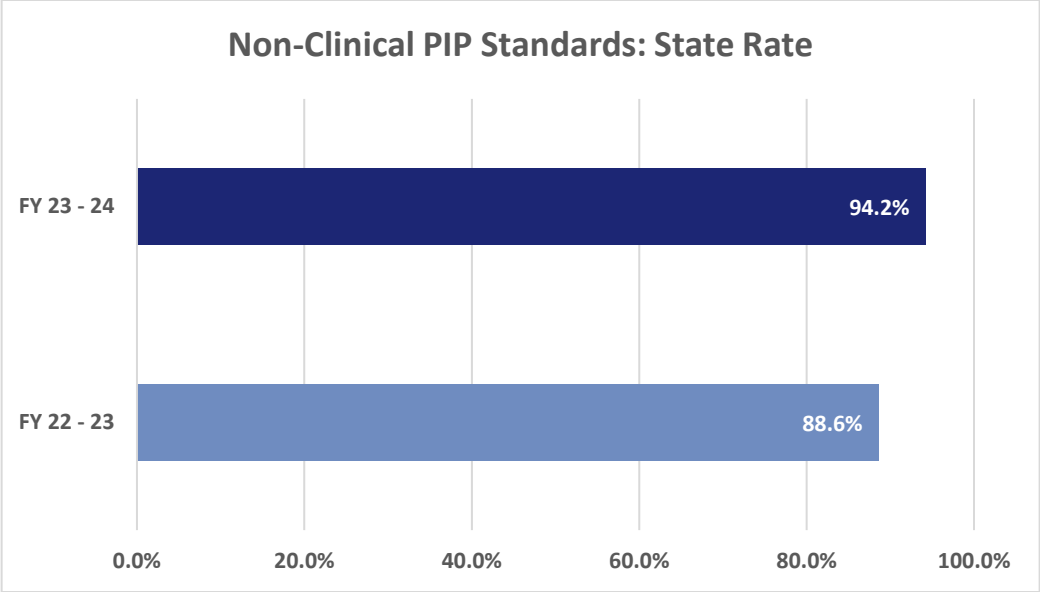
Methodology

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

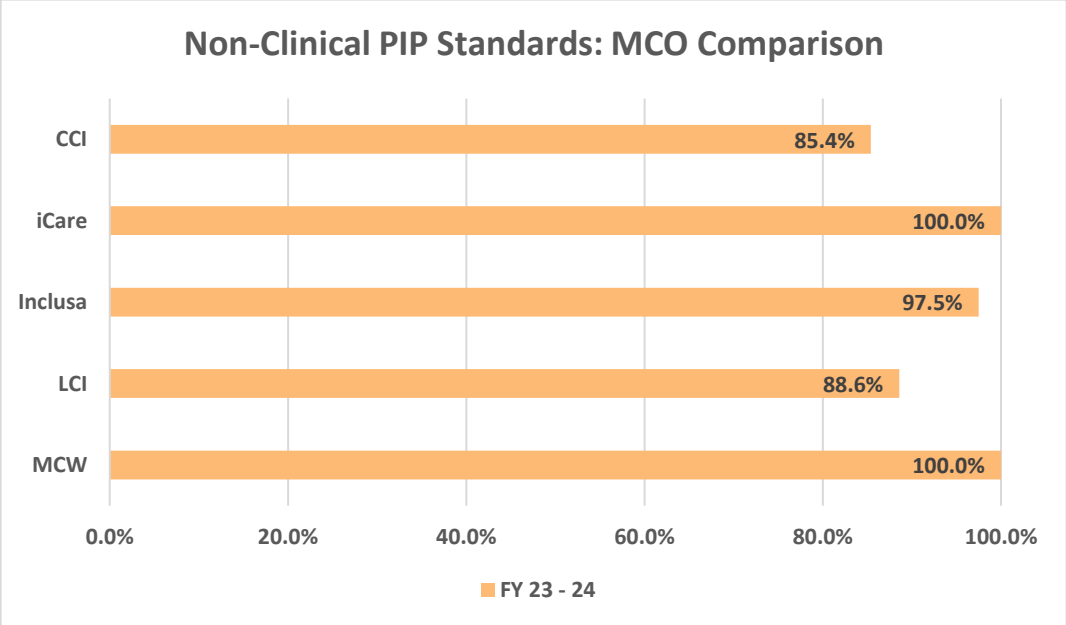
FY 23-24 Methodology Rating – Non-Clinical PIP			
Standards	**Scoring Elements**	**Percentage**	**Methodology Rating**
Standard 1: PIP Topic	20/20	100.0%	High Confidence
Standard 2: PIP Aim Statement	30/30	100.0%	High Confidence
Standard 3: PIP Population	9/10	90.0%	High Confidence
Standard 4: Sampling Method*	N/A	N/A	N/A
Standard 5: PIP Variables and Performance Measures	23/25	92.0%	High Confidence
Standard 6: Data Collection Procedures	41/41	100.0%	High Confidence
Standard 7: Data Analysis and Interpretation of PIP Results	31/32	96.9%	High Confidence
Standard 8: Improvement Strategies	29/30	96.7%	High Confidence
Standard 9: Significant and Sustained Improvement	11/18	61.1%	No Confidence
Methodology Rating	**194/206**	**94.2%**	**High Confidence**

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

The graph on the next page illustrates the State's overall compliance with these standards in FY 23-24 and compares the score to the same standards reviewed in FY 22-23.



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



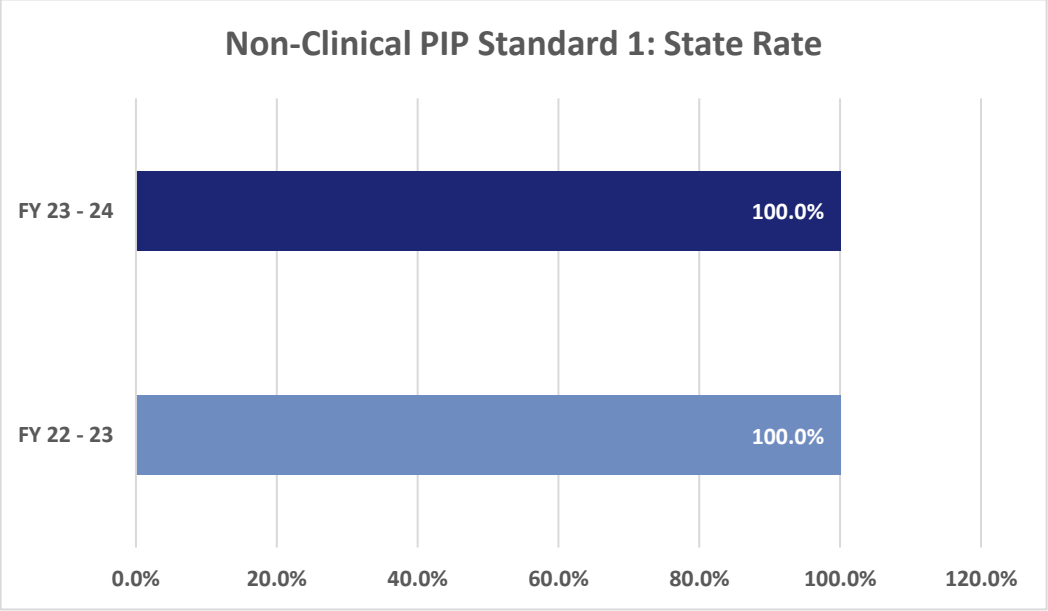
Observation and Analysis: Standard 1. PIP Topic

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

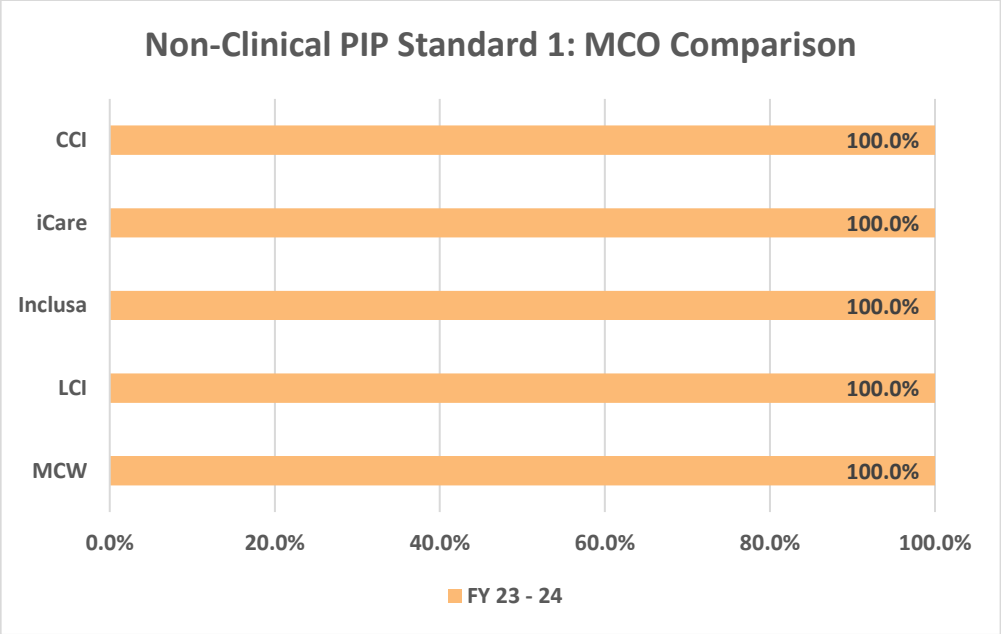
All topics should address areas of special populations or high priority services. Standard 1 evaluated each PIP on five possible scoring elements. Collectively, the MCOs satisfied requirements for 20 out of 20 scoring elements, for a score of 100.0 percent.

All non-clinical topics included an analysis of topic selection and the 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 23-24 and compares the score to the same standard reviewed in FY 22-23.



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 evaluated each PIP on six possible scoring elements. Collectively, the MCOs satisfied requirements for 30 out of 30 scoring elements, for a score of 100.0 percent.

Aim statements for all non-clinical projects included the required criteria. All aim statements were concise.

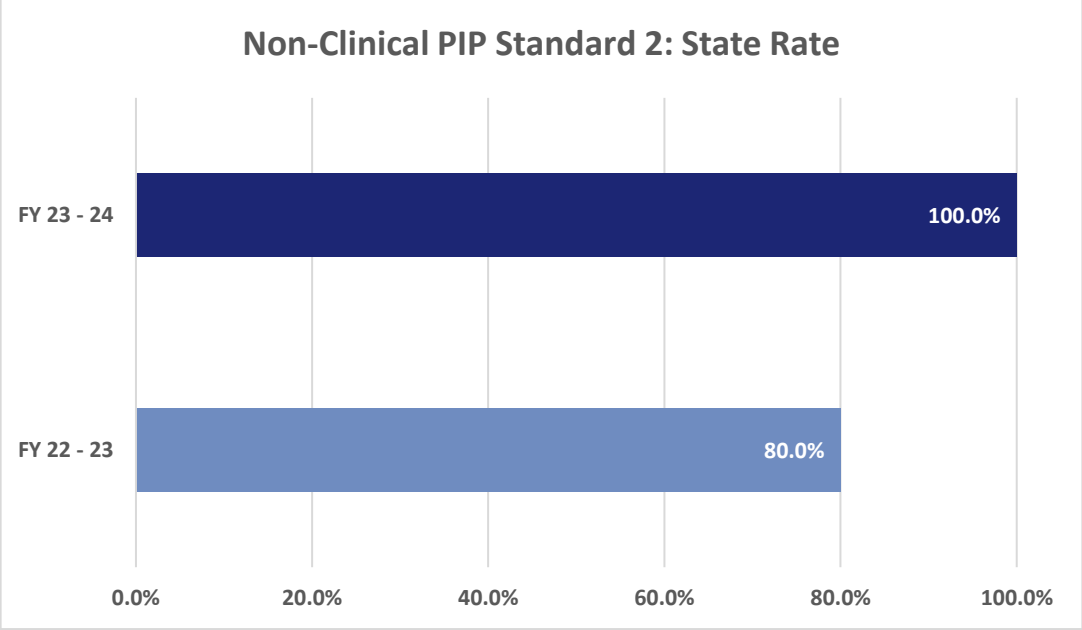
The table below identifies the aim statements for each non-clinical PIP topic. The aim statements in the table are copied from the PIP reports submitted by the organizations. No adjustments or edits were made by MetaStar.

MCO	Non-Clinical Topic	Aim Statement
CCI	Electronic Health Records	Aim A: "Can an education campaign increase registered Waukesha County Family Care members (including new and continuously enrolled) in the CCI MyHealthRecord between 4/1/23 and 11/30/23 by 1.2% from 0 members to 17 members?" Aim B: "Can an education campaign increase registered Waukesha County Family Care Partnership members (including new and continuously enrolled) in the CCI MyHealthRecord

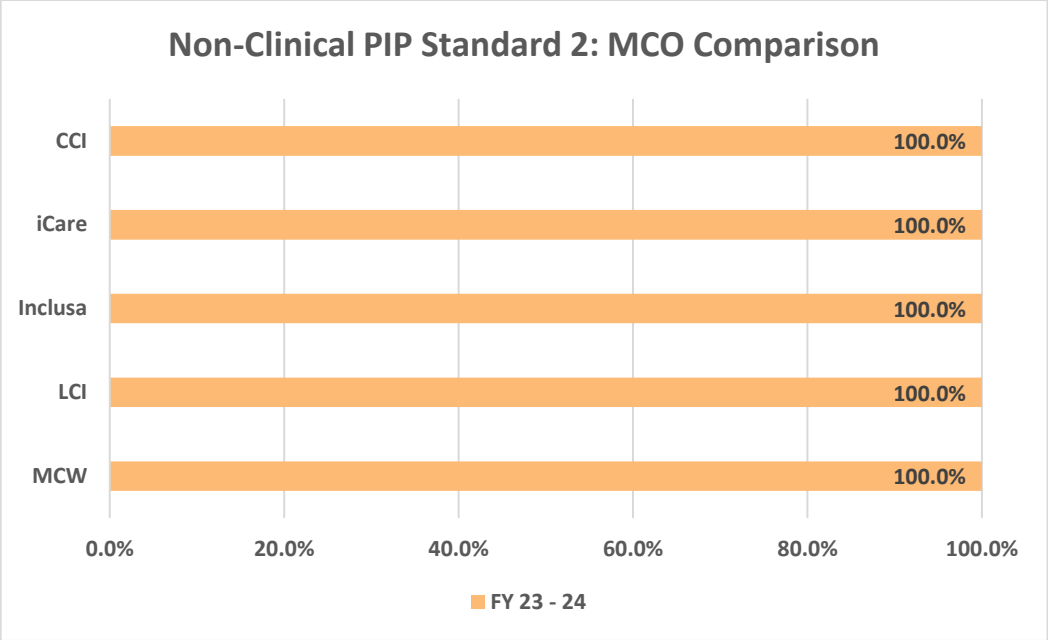
MCO	Non-Clinical Topic	Aim Statement
		between 4/1/23 and 11/30/23 by 10% from 1 member to 6 members?" Aim C: "Can an education campaign increase registered Waukesha County PACE members (including new and continuously enrolled) in the CCI MyHealthRecord between 4/1/23 and 11/30/23 by 10% from 3 members to 10 members?"
*i*Care	Behavioral Support	"With BH targeted outreach (telephonic or face-to-face) from the iCare FCP IDT staff, the percent of eligible iCare FCP PD members with one or more BH diagnosis who utilize an outpatient visit for BH will increase from 37% to 42% from 01/01/2023-10/31/2023."
Inclusa	Health Equity	"Through the implementation of a D365 assessment questionnaire, specific to the 8 dimensions of wellness and social determinants of health, will the comprehensiveness of the member assessment be improved by including a completed assessment of member identified ratings for each dimension/determinant topic, from 0% of completed assessment questionnaires as of February 1, 2023 (baseline) to 41% of completed assessment questionnaires by October 1, 2023 (repeat) for all enrolled members with comprehensive member assessment reviews due in the months of June, July, and August and completed in the D365 system during the 2023 project year?"
LCI	Member Satisfaction	"Does providing enhanced education and materials about Self-Directed Supports (SDS) to IDT staff who support Target Group 1 (LCI members whose IDT (Interdisciplinary Team) staff are supervised by Becky Williams, Ewa Asher, Megan Davis, Nicole Leiter, Lauren Hish, and Stacey Kalies who receive and return LCI's member satisfaction survey between May 1, 2023 and October 31, 2023) result in improved member satisfaction with their understanding of the SDS program as evidenced by T2B ('Extremely' or 'Very') responses on the LCI Member Satisfaction survey for the question, 'How Well did your Care Team explain the Self-Directed Supports option to you?' increasing from 62.4% to 64.4%?"
MCW	Caregiver Strain	Aim A: "Will implementation of Caregiver Stress and Strain Resource training with care management staff and increased availability of additional caregiver resources, increase the percentage of FC and FCP members with Caregiver Self-Assessment Questionnaires completed who receive caregiver stress and strain education from 44.4% (7/1/2022-7/31/2022) to 50%* (5/1/2023-5/31/2023)?"

MCO	Non-Clinical Topic	Aim Statement
		Aim B: "Following implementation of Caregiver Stress and Strain Resource training with care management staff, increased availability of additional caregiver resources, and increased caregiver stress and strain education with members, will the percentage of FC & FCP members with most recent Caregiver Self-Assessment Questionnaire scores indicating "At Risk for Caregiver Distress" decrease from 20.7% (7/1/2022-1/31/2023) to 19.1%* (5/1/2023-11/30/2023)?"

The graph below illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



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

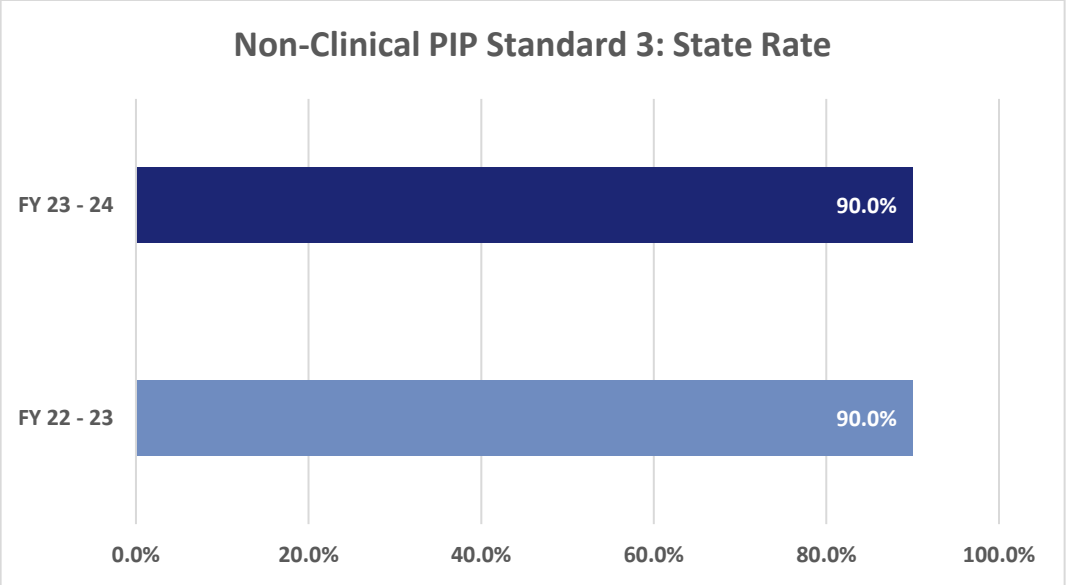


Observation and Analysis: Standard 3. PIP Population

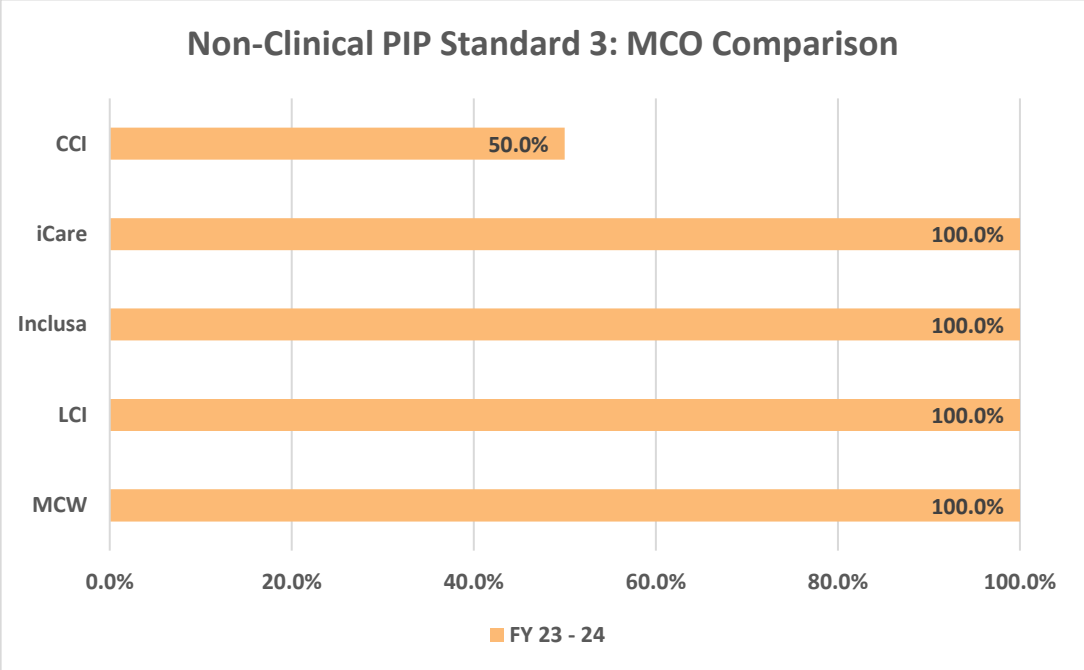
The MCOs must clearly define the project's population, identifying all inclusionary and exclusionary criteria. If the entire eligible MCOs population is included in the project, the data collection approach must ensure it captures all applicable members. Standard 3 evaluated each PIP on two possible scoring elements. Collectively, the organizations satisfied requirements for nine out of 10 scoring elements, for a score of 90.0 percent.

All but one non-clinical project clearly defined the PIP populations related to the aim statements.

The graph on the next page illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



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



Observation and Analysis: Standard 4. Sampling Method

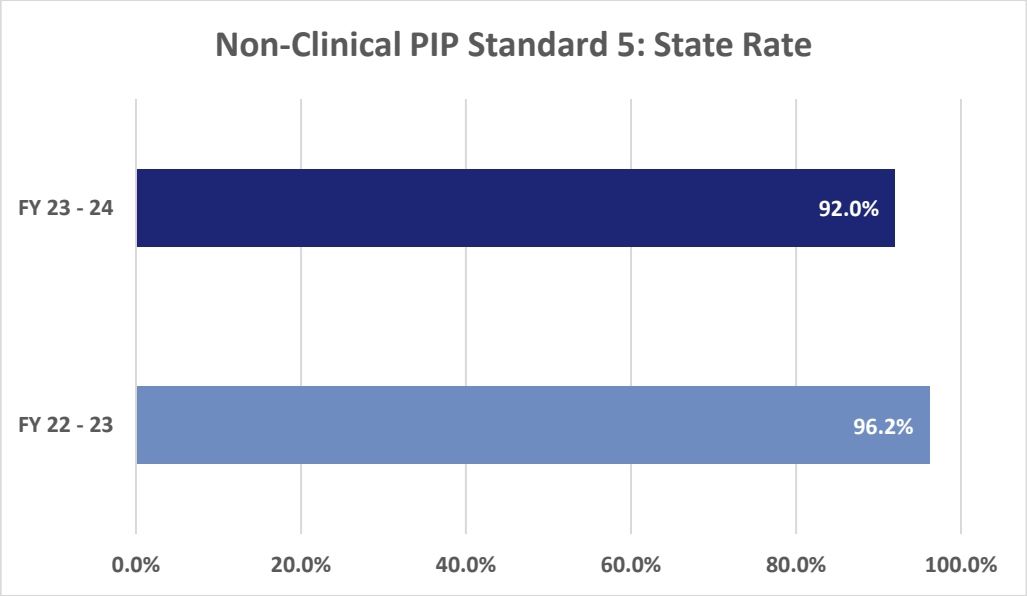
The MCOs must have appropriate sampling methods to ensure data collection produces valid and reliable results. Sampling was not used for any non-clinical projects in FY 23-24 or FY 22-23; therefore, there are no results for this standard to display.

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

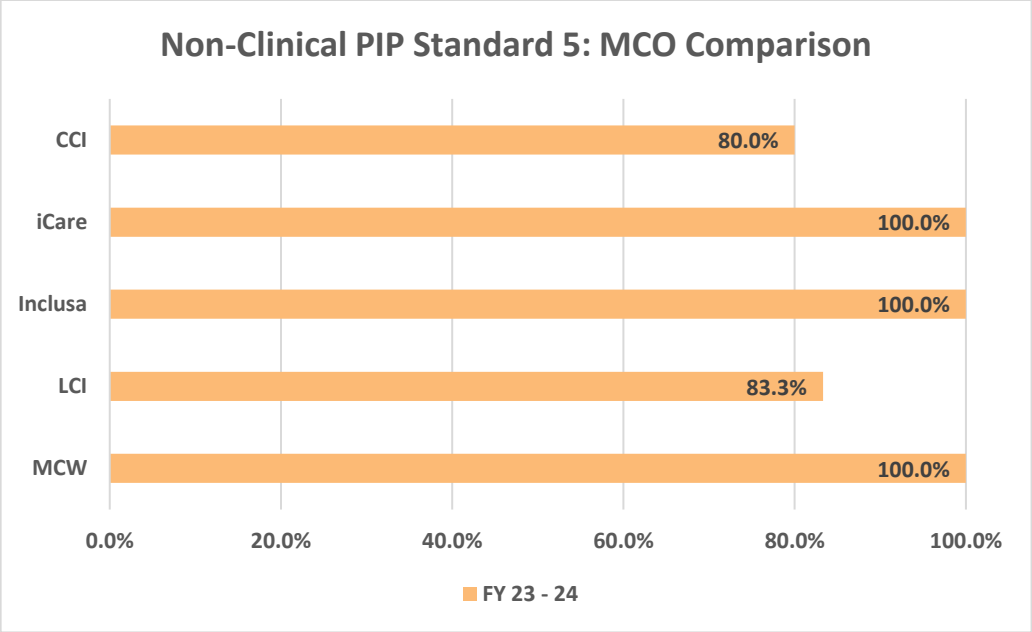
MCOs must select variables that identify the MCO's performance on the PIP questions objectively and reliably, using clearly defined indicators of performance. The PIP should include the number and type of variables that are adequate to answer the PIP question, can measure performance, and can track improvement over time. Standard 5 evaluated each PIP on 10 possible scoring elements. Collectively, the MCOs satisfied requirements for 23 out of 25 scoring elements, for a score of 92.0 percent.

All non-clinical PIPs include performance measures that assessed an important aspect of member care and were able to be tracked and monitored over time. When applicable, the PIP included a strategy to ensure interrater reliability.

The graph below illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



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



Observation and Analysis: Standard 6. Data Collection Procedures

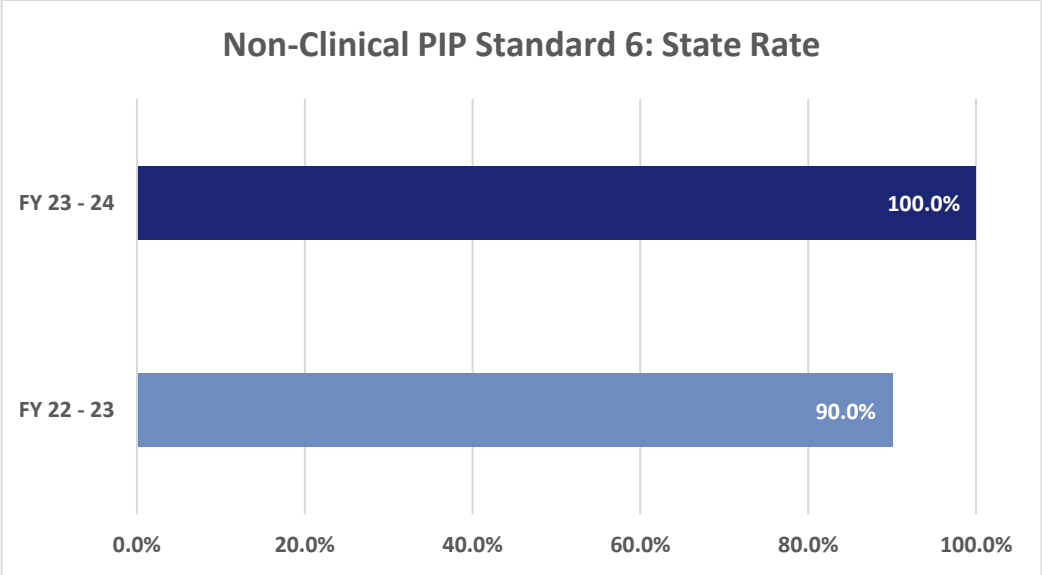
MCOs must establish data collection procedures that ensure valid and reliable data throughout the project. The data collection plan should specify the following:

- 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.

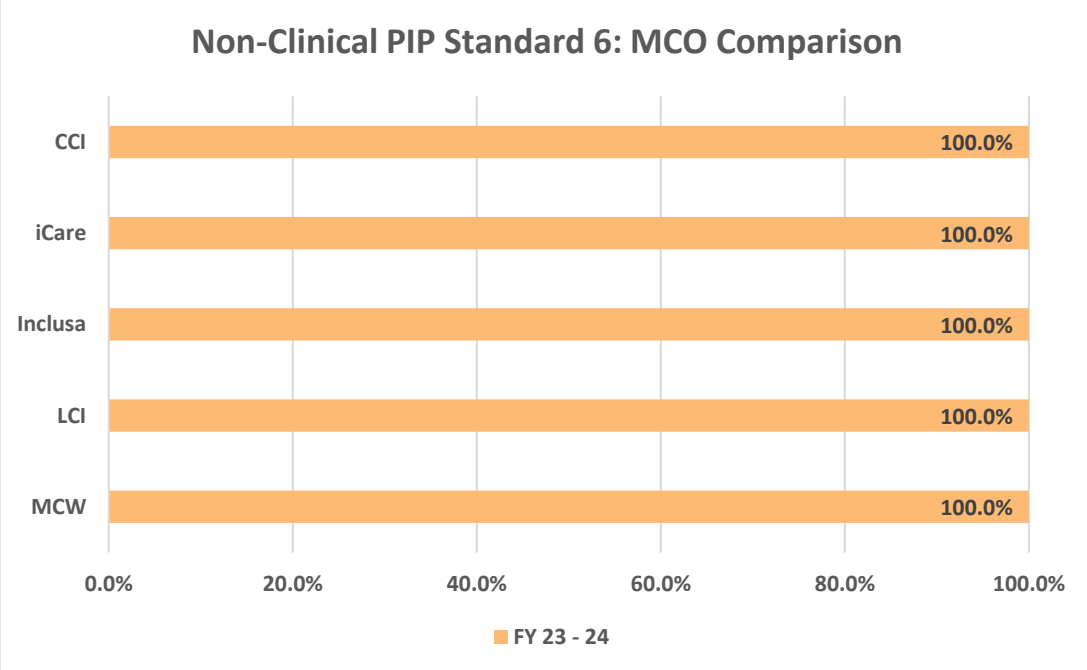
Standard 6 evaluated each PIP on 16 possible scoring elements. Collectively, the MCOs satisfied requirements for 41 out of 41 scoring elements, for a score of 100.0 percent.

All non-clinical projects detailed data collection process to ensure that appropriate data would be available for the PIPs. Each project clearly defined the data sources and collection methods to be used.

The graph on the next page illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



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



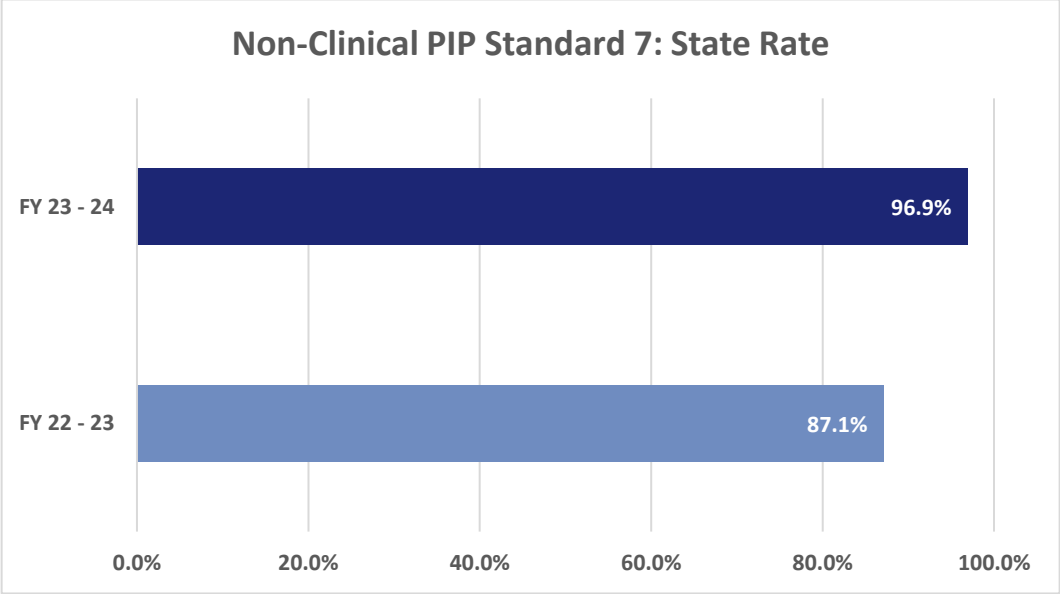
Observation and Analysis: Standard 7. Data Analysis and Interpretation of PIP Results

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 evaluated each PIP on eight possible scoring

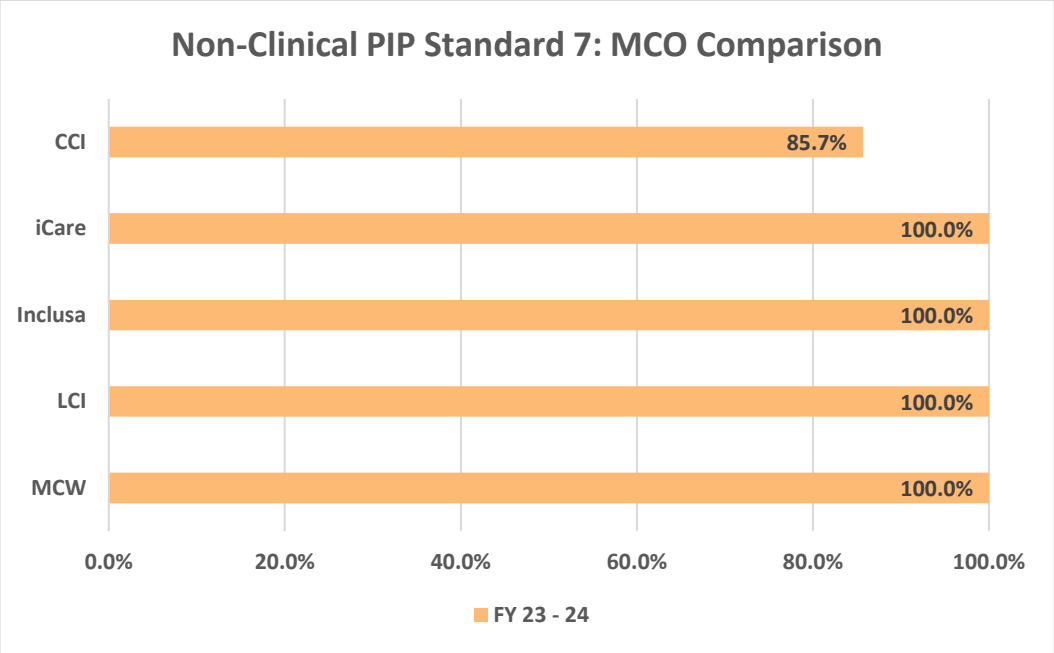
elements. Collectively, the MCOs satisfied requirements for 31 out of 32 scoring elements, for a score of 96.9 percent.

All non-clinical PIPs completed the data analysis according to the data analysis plan and contained evidence of statistical assessment to test the change between initial and repeat measurements. All projects presented findings in a concise and easily understood manner.

The graph below illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



The graph on the next page 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 evaluated each PIP on six possible scoring elements. Collectively, the MCOs satisfied requirements for 29 out of 30 scoring elements, for a score of 96.7 percent.

All non-clinical PIPs utilized evidence-based improvement strategies and PDSA cycles to test the effectiveness of the strategies. All strategies utilized were culturally and linguistically appropriate.

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

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

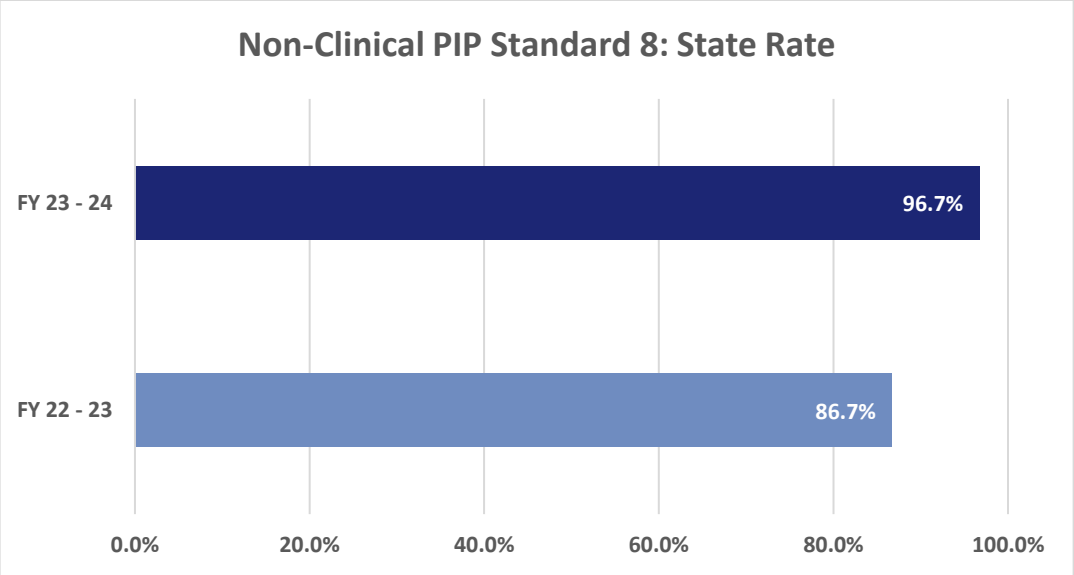
Improvement Strategy Effectiveness Ratings	
Not Implemented	MCO did not implement the strategy.

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

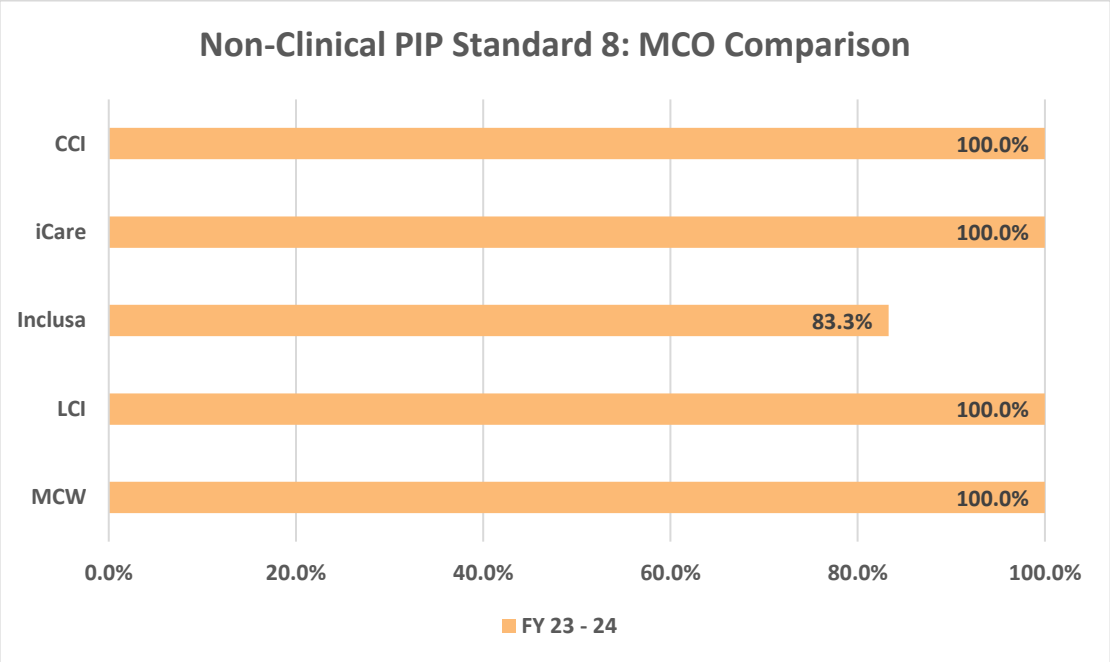
MCO	Topic	Non-Clinical Improvement Strategies	Effectiveness
CCI	Electronic Health Records	Trained staff on project and how to assist members with MyHealthRecord enrollment.	Effective
CCI	Electronic Health Records	Discussed electronic health record with members and legal decision-makers and assist with enrollment.	Effective
CCI	Electronic Health Records	Offered gift card incentive to staff for registrations.	Effective
*i*Care	Behavioral Support	Conducted face-to-face or telephonic outreach with members.	Effective
Inclusa	Health Equity	Implementation of a D365 assessment questionnaire, specific to the 8 dimensions of wellness and social determinants of health.	Effective*
LCI	Member Satisfaction	Provided education and resources to CMs about SDS to improve the CM's ability to discuss SDS services with the member.	Effective
MCW	Caregiver Strain	Conduct Caregiver Stress and Strain Resource training with care management staff.	Effective
MCW	Caregiver Strain	Increase availability of additional caregiver resources.	Effective
MCW	Caregiver Strain	Increase caregiver stress and strain education with members.	Effective

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

The graph on the next page illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



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 11 out of 18 scoring elements, for a score of 61.1 percent.

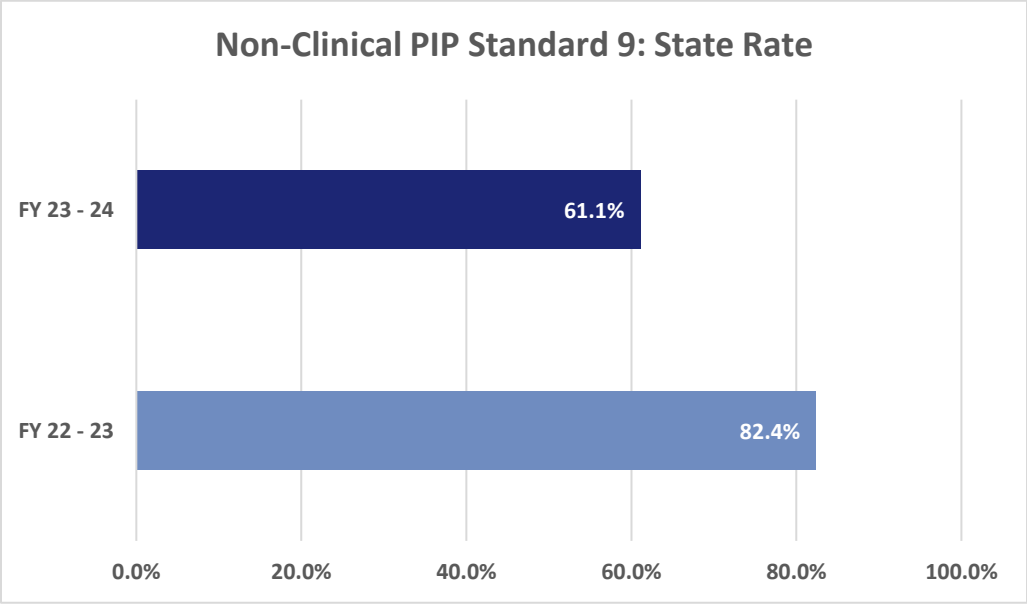
Scoring element 9.1 evaluated using the same methodology for the project's baseline and repeat measurements. The projects submitted by CCI and LCI did not use the same methodology to calculate each measurement.

Scoring element 9.2 evaluated if there was quantitative evidence of improvement. The projects submitted by CCI and LCI could not be evaluated for quantitative improvement due to the change in methodology for calculating the baseline and repeat measurements.

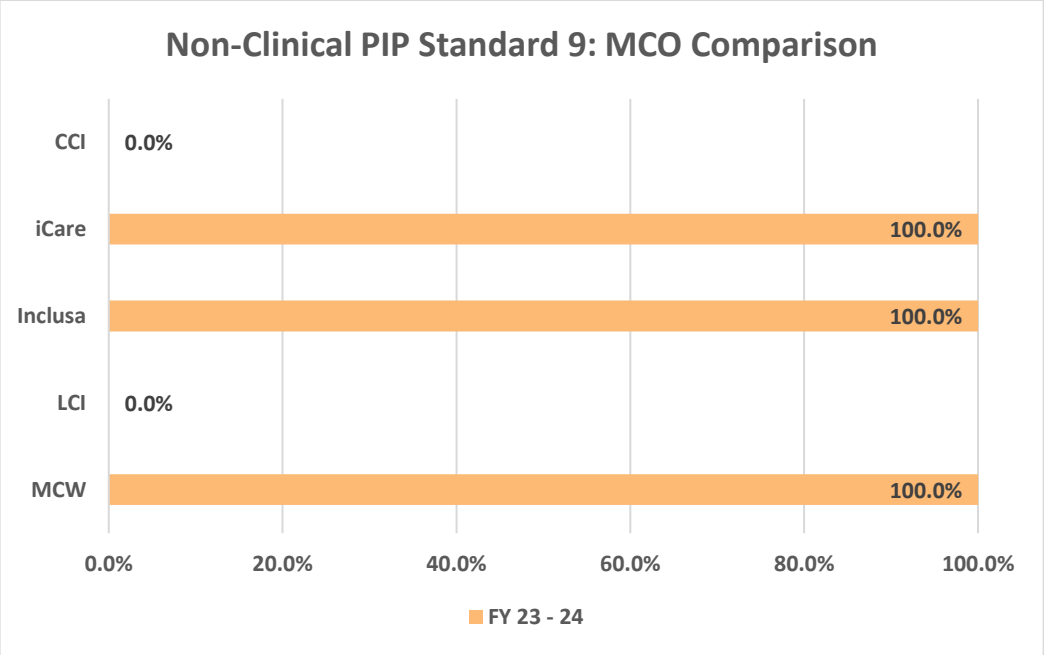
Scoring element 9.3 assessed if the reported improvement in performance was likely to be the result of the selected intervention. This was not able to be evaluated in the CCI and LCI projects that used different methodology in the baseline and repeat measurements.

Scoring element 9.4 evaluated if there is statistical evidence that the observed improvement is the result of the intervention. Due to the lack of comparability between measures in the LCI PIP, valid statistical testing could not be completed.

The graph below illustrates the State's overall compliance with this standard in FY 23-24 and compares the score to the same standard reviewed in FY 22-23.



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



Significant Improvement

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

MCO	Topic	Baseline Measurement	Repeat Measurement	Significant Improvement Rating
CCI Aim A	Electronic Health Records	0 of 1,458 FC members registered in electronic health record	12 of 1,479 FC members registered in electronic health record	High Confidence
CCI Aim B	Electronic Health Records	1 of 54 FCP members registered in electronic health record	20 of 55 FCP members registered in electronic health	High Confidence
CCI Aim C	Electronic Health Records	7 of 76 PACE members registered in electronic health record	10 of 73 PACE members registered in electronic health record	Low Confidence*
*i*Care	Behavioral Support	201 members utilized a BH outpatient visit/541 eligible members	227 members utilized a BH outpatient visit/543 eligible members	Low Confidence
Inclusa	Health Equity	0 of 3,483 members have a completed	2,812 of 4,724 members have a completed	High Confidence

MCO	Topic	Baseline Measurement	Repeat Measurement	Significant Improvement Rating
		dimensions/determinants assessment tool	dimensions/determinants assessment tool	
LCI	Member Satisfaction	73 of 117 members with survey responses of "'extremely" or "very'" for how well the care team explained SDS	119 of 164 members with survey responses of "'extremely" or "very'" for how well the care team explained SDS	No Confidence*
MCW Aim A	Caregiver Strain	205 of 462 members educated	875 of 1,209 members educated	High Confidence
MCW Aim B	Caregiver Strain	772 of 3,726 members with caregivers at risk for Caregiver Strain	614 of 3,093 members with caregivers at risk for Caregiver Strain	No Confidence

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

Progress on Previous EQRO Plan Level Recommendations

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

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

The table below identifies the recommendations made the by the EQRO in the prior review, FY 22-23, the actions taken by the MCO to address the recommendations, and the degree to which the MCO addressed the recommendations.

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCI	– Specify a time period for each aim statement, including a start and end date. – Ensure the aim statements are answerable.	– The MCO identified time periods with a start and end date for all aim statements. – The MCO ensured aim statements were answerable.	High

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Include the frequency of data collection in the report. – 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.	– The MCO specified the frequency of data collection. – The MCO ensured the analysis plan corresponded to the data collection plan. – The MCO assessed the statistical significance of initial and repeat measures for all aim statements. – The MCO ensured project results were concise and easily understood. – The MCO conducted statistical testing for each aim with observed improvement.	
iCare	– 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.	– The aim statements included specified time periods for the projects. – The aim statements were answerable. – Inclusion and exclusion criteria for the study population were specified for the projects. – The projects included a comparison of results across multiple entities, such as different member subgroups, provider sites, or other MCOs. – The same methodology was used to calculate the baseline and repeat measures.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– 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. – Complete statistical testing of comparable measures.		
Inclusa	– Specify a time period for each aim statement, including a start and end date. – Ensure the aim statements are answerable. – 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. – Ensure the analysis plan corresponds to the data collection plan. – Ensure data analysis plans are established for all project aims in future reports.	– The MCO identified time periods with a start and end date for all aim statements. – The MCO ensured aim statements were measurable. – The MCO clearly defined all inclusion and exclusion criteria for the study population. – The MCO described the process utilized to confirm all eligible members are included in the study population. – The MCO specified the frequency of data collection. – The MCO identified all data collection methods. – The MCO ensured the analysis plan corresponded to the data collection plan. – The MCO ensured data analysis plans were established for all project aims.	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– 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.	– The MCO compared project results with other entities and/or subgroups.	
LCI	– Include the specific measures or results that were tested for statistical significance and statistical evidence in future reports.	– The MCO included the specific measures or results that were tested for statistical significance.	High
MCW	– Identify time periods with start and end dates for all aim statements in future reports. – 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	– The aim statements included specific time periods for the projects to be conducted. – The project populations were clearly identified and consistent with the aim statement. – The projects included variables that were adequate to answer the study questions.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	true final rate for all aim statements, and ensure initial and repeat measures use the same methodology in order to be comparable.		

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 2023, which are set forth in Addendum III of the 2023 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 2023. 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 are summarized below for the following MCOs and programs:

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

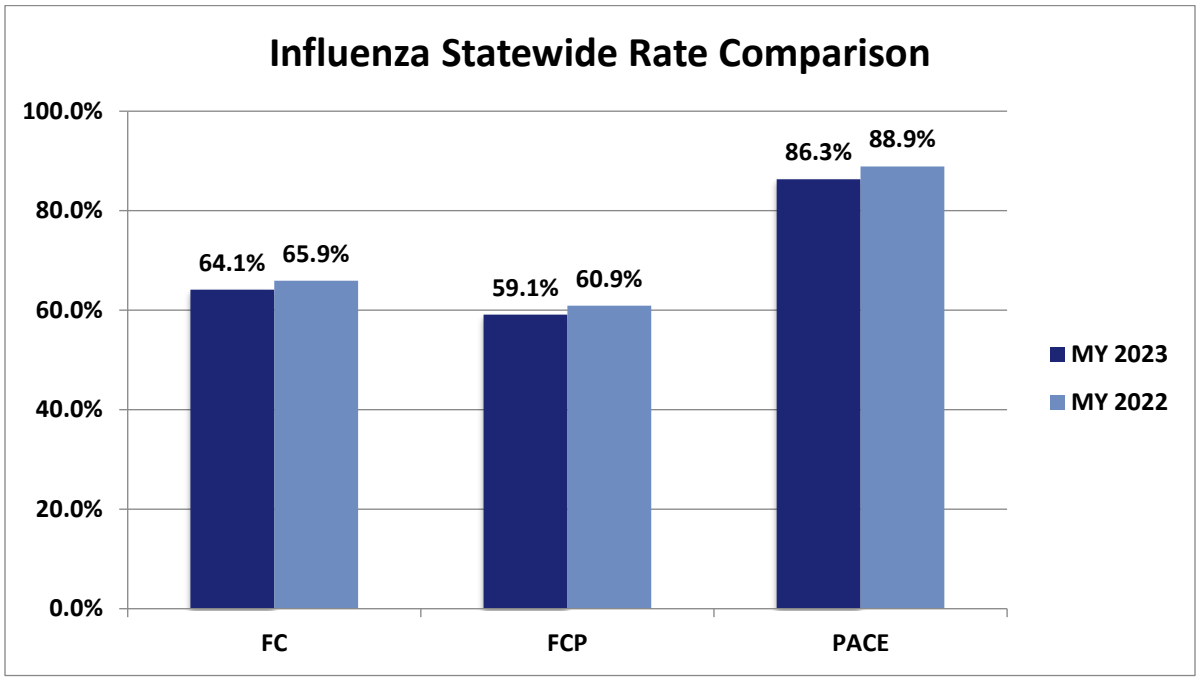
Managed Care Organization	Program(s)
My Choice Wisconsin, Inc. (MCW)	FC; FCP

Influenza Vaccination Rates

The following table shows information about the influenza vaccination rates, by program, for MY 2023 and compares the rates to vaccination rates in MY 2022.

Statewide Influenza Vaccination Rates by Program				
	MY 2023			MY 2022
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	44,243	28,345	64.1%	65.9%
Family Care Partnership	2,947	1,741	59.1%	60.9%
PACE	424	366	86.3%	88.9%

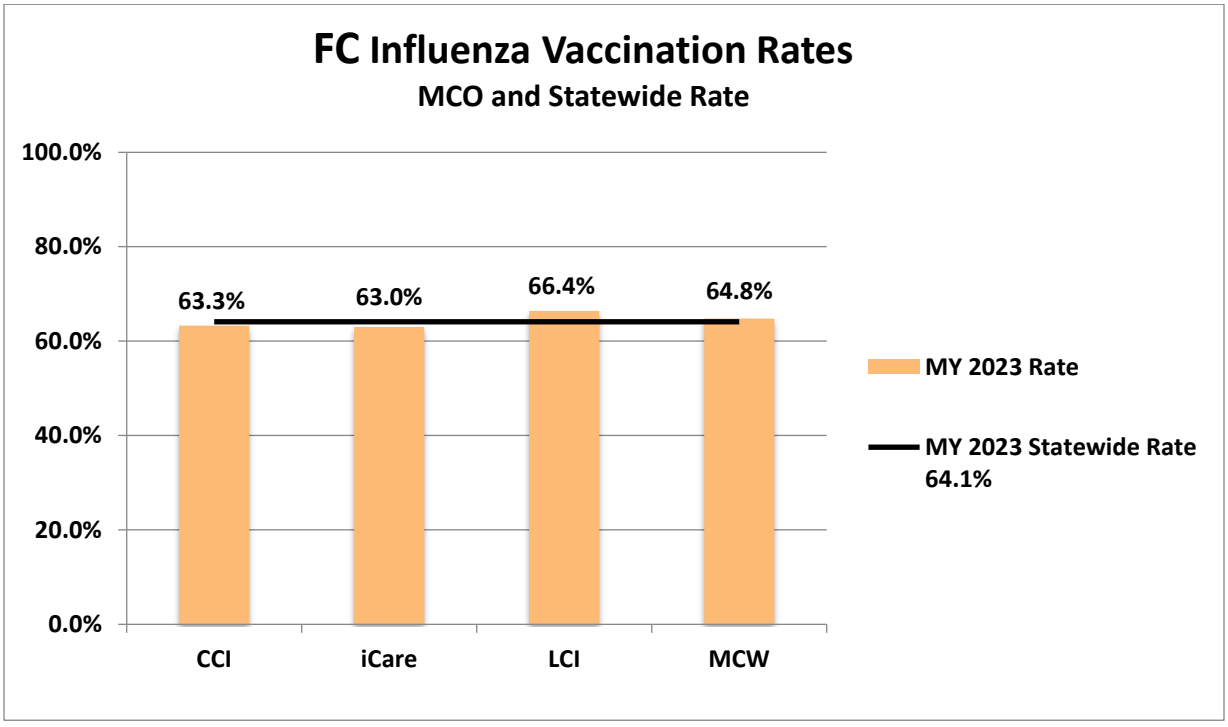
Influenza vaccination statewide rates, by program, for MY 2023 and MY 2022 are shown in the following graph.



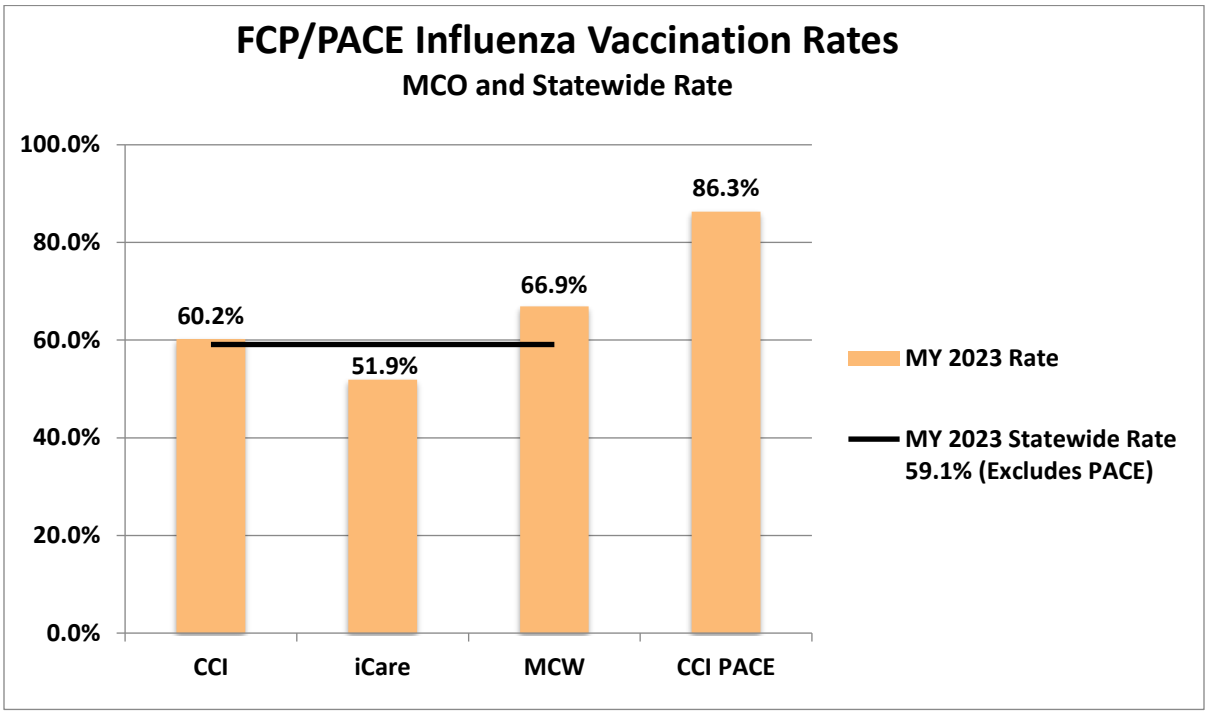
The table on the next page shows influenza vaccination rates by program and MCO for MY 2023 and MY 2022.

Influenza Vaccination Rates by Program and Measurement Year				
Program/MCO	MY 2023			MY 2022
	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care				
CCI	11,261	7,127	63.3%	65.8%
*i*Care	14,365	9,055	63.0%	64.0%
LCI	6,013	3,993	66.4%	67.9%
MCW	12,604	8,170	64.8%	67.2%
Family Care Partnership				
CCI	605	364	60.2%	65.5%
*i*Care	1,263	655	51.9%	50.5%
MCW	1,079	722	66.9%	68.8%
PACE				
CCI	424	366	86.3%	88.9%

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



The graph below 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

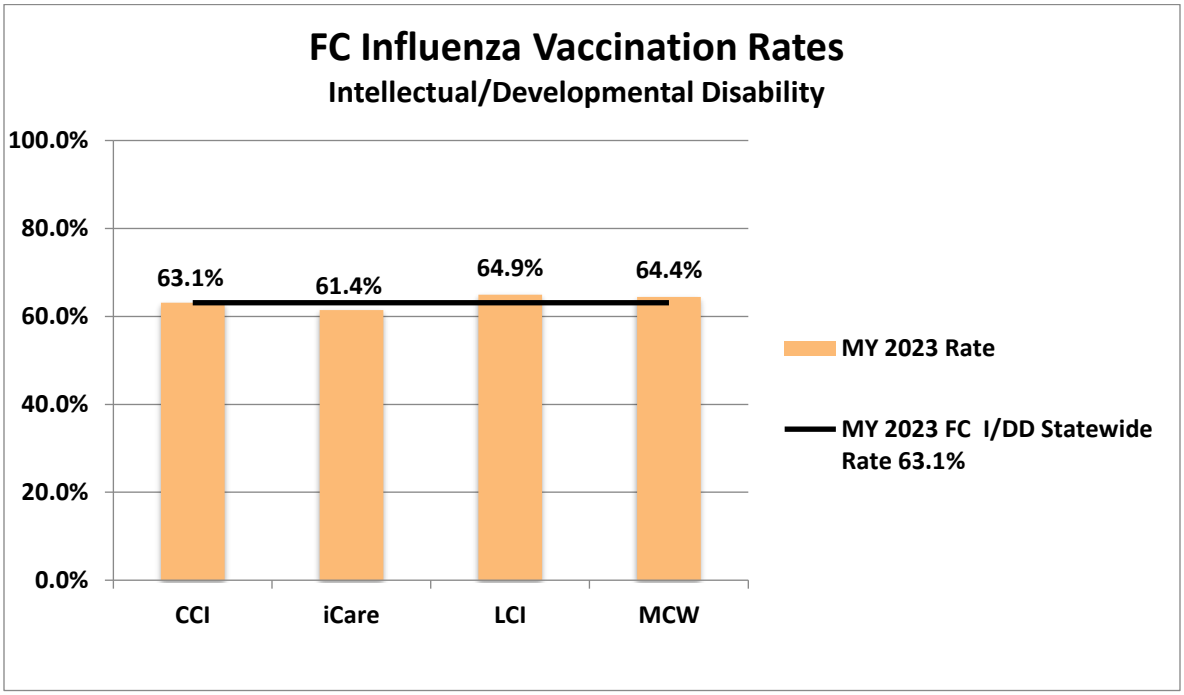
For each program (FC, FCP, and PACE), influenza vaccination rates varied by target group as shown in the table below.

MY 2023 Influenza Vaccination Rates by Program and Target Group			
Program/Target Group	**Eligible Members**	**Number Vaccinated**	**Vaccination Rate**
Family Care			
Intellectual/Developmental Disability	21,710	13,709	63.1%
Frail Elder	15,017	10,604	70.6%
Physical Disability	7,516	4,032	53.6%
Family Care Partnership			
Intellectual/Developmental Disability	914	536	58.6%
Frail Elder	1,075	723	67.3%
Physical Disability	958	482	50.3%

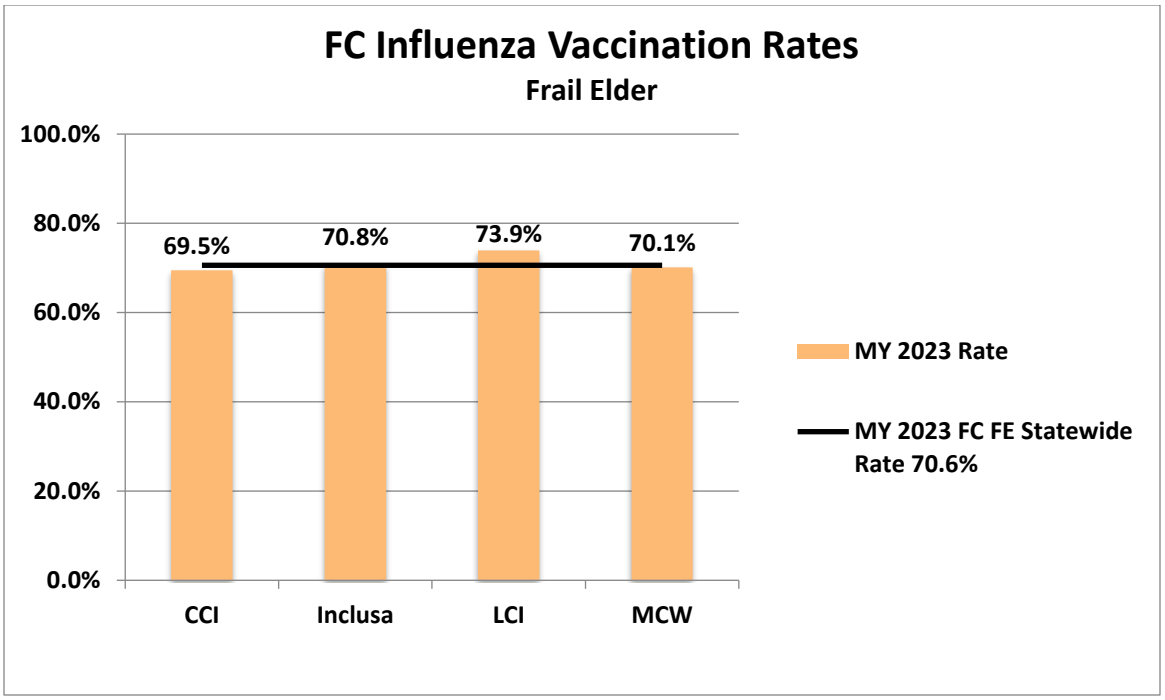
PACE			
Intellectual/Developmental Disability	50	46	92.0%
Frail Elder	341	297	87.1%
Physical Disability	33	23	69.7%

Family Care

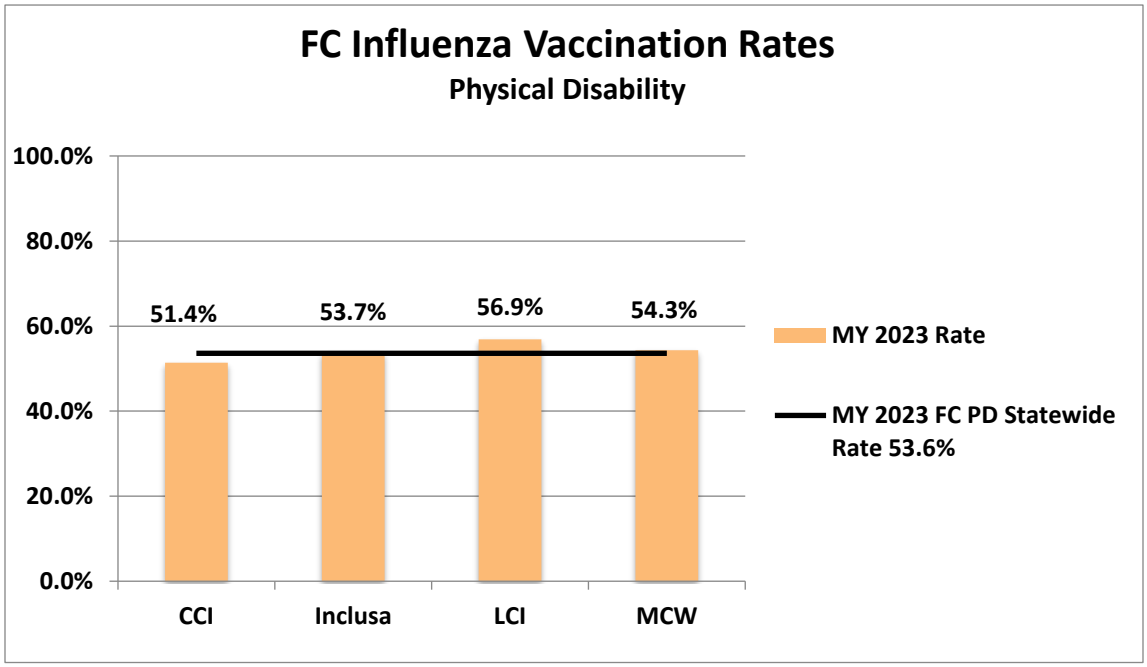
The graph below shows influenza vaccination rates for FC members in the Intellectual/ Developmental Disability target group, by MCO, for MY 2023.



The graph on the next page shows influenza vaccination rates for FC members in the Frail Elder target group, by MCO, for MY 2023.

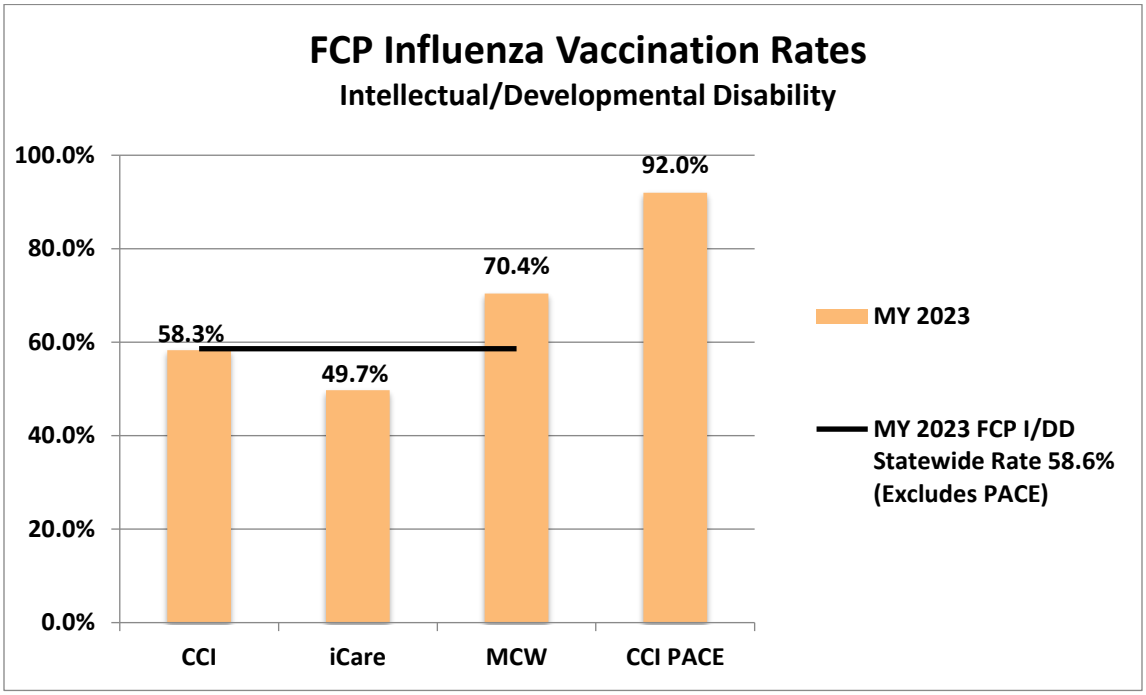


The graph below shows influenza vaccination rates for FC members in the Physical Disability target group, by MCO, for MY 2023.

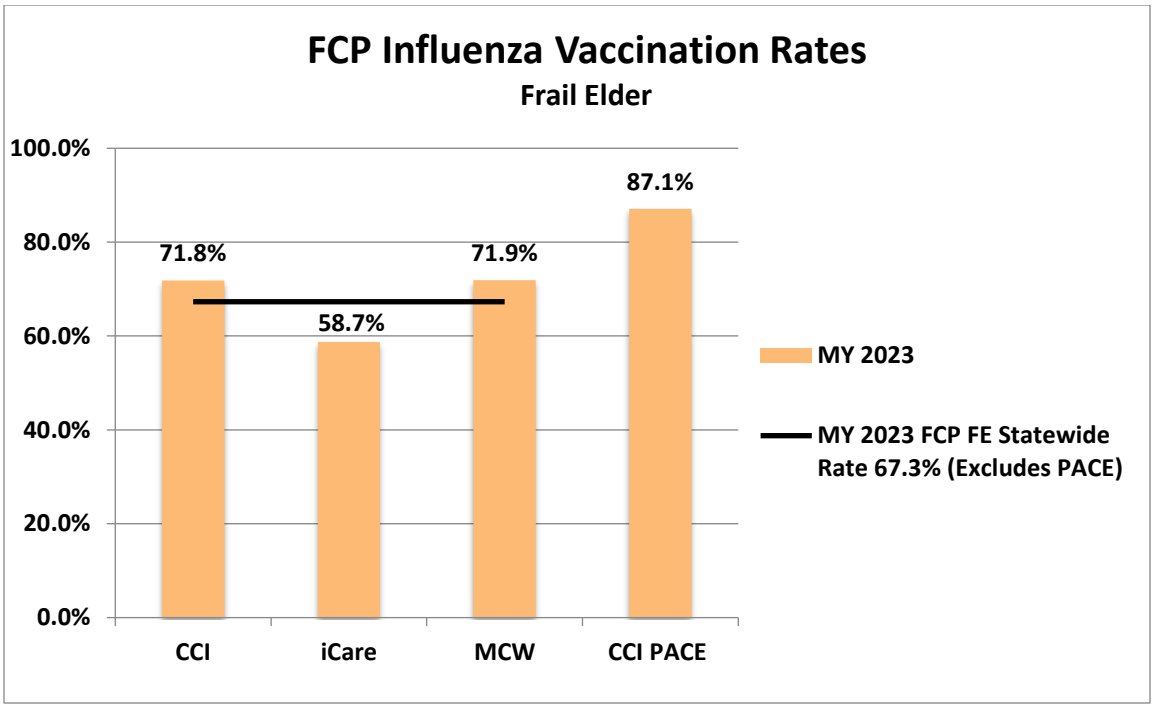


Family Care Partnership/PACE

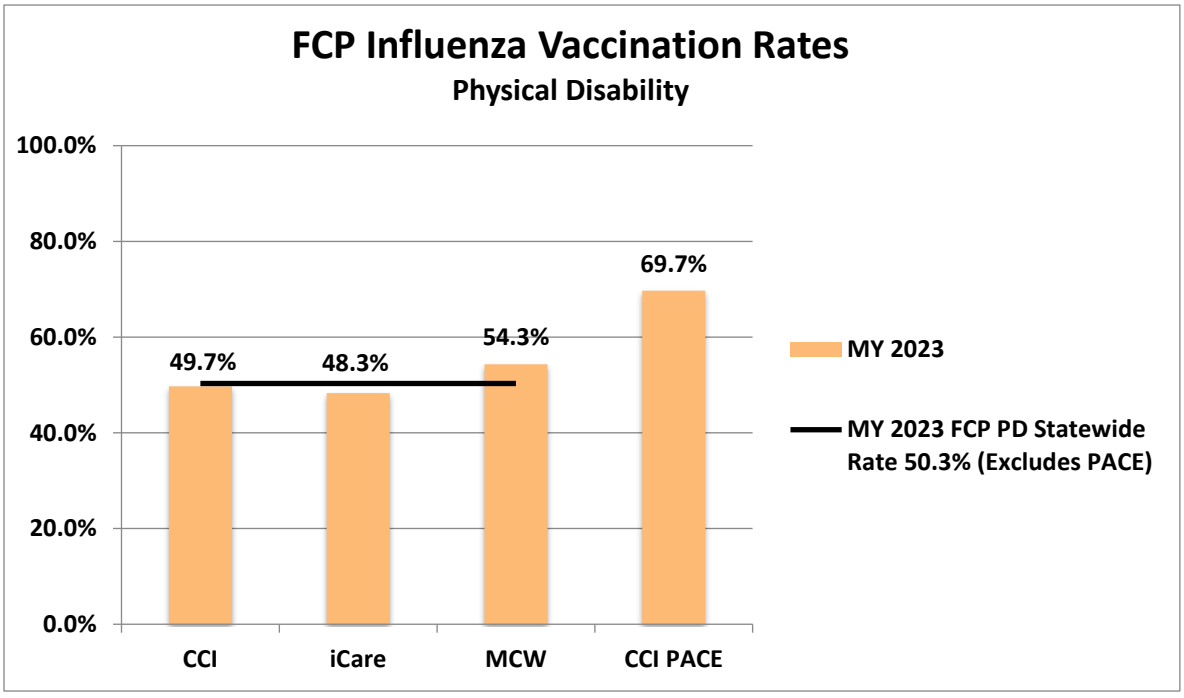
The graph below shows influenza vaccination rates for FCP and PACE members in the Intellectual/Developmental Disability target group, by MCO, for MY 2023.



The graph on the next page shows influenza vaccination rates for FCP and PACE members in the Frail Elder target group, by MCO, for MY 2023.



The graph below shows influenza vaccination rates for FCP and PACE members in the Physical Disability target group, by MCO, for MY 2023.

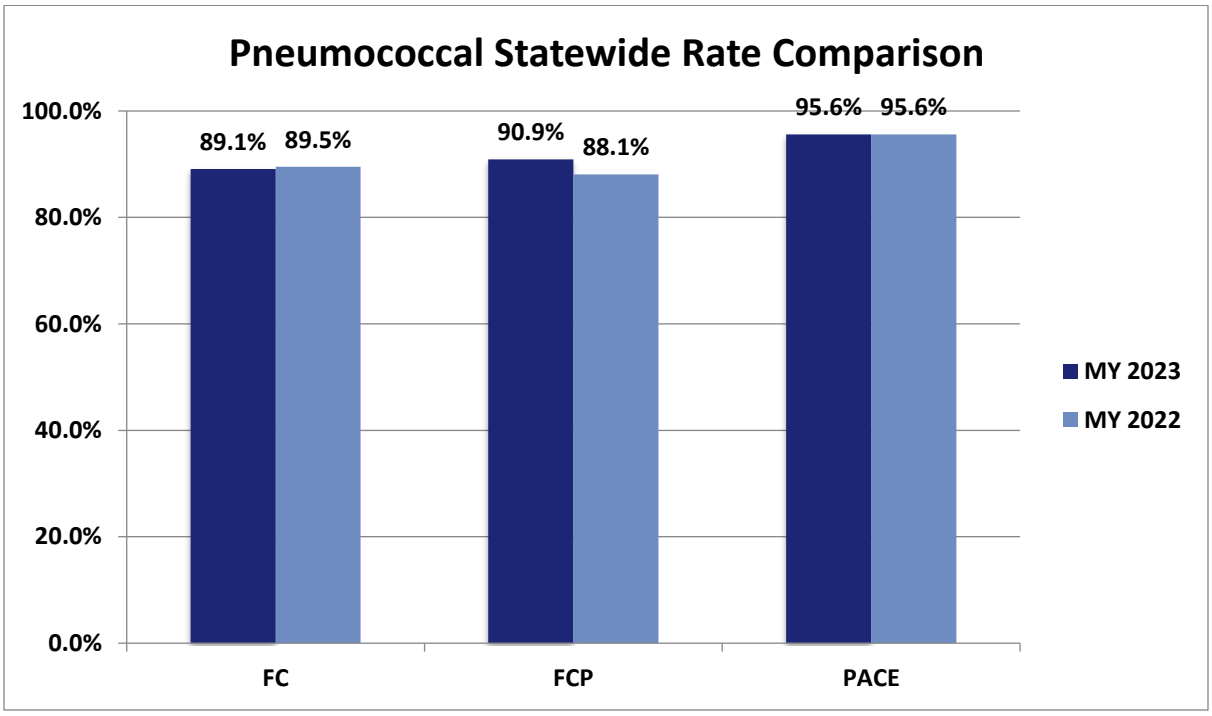


Pneumococcal Vaccination Rates

The table below shows information about the pneumococcal vaccination rates, by program, for MY 2023 and compares the MY 2023 rates to vaccination rates in MY 2022.

Statewide Pneumococcal Vaccination Rates by Program				
	MY 2023			MY 2022
Program	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care	20,891	18,605	89.1%	89.5%
Family Care Partnership	1,311	1,192	90.9%	88.1%
PACE	411	393	95.6%	95.6%

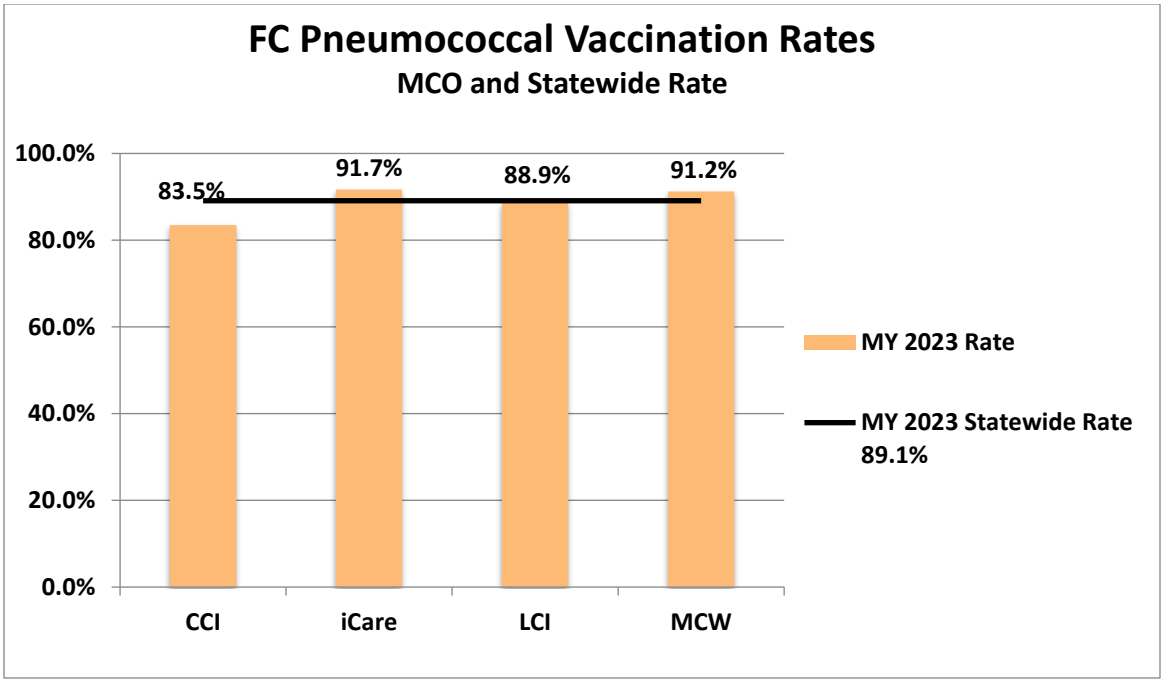
Pneumococcal vaccination statewide rates, by program, for MY 2023 and MY 2022 are shown in the following graph.



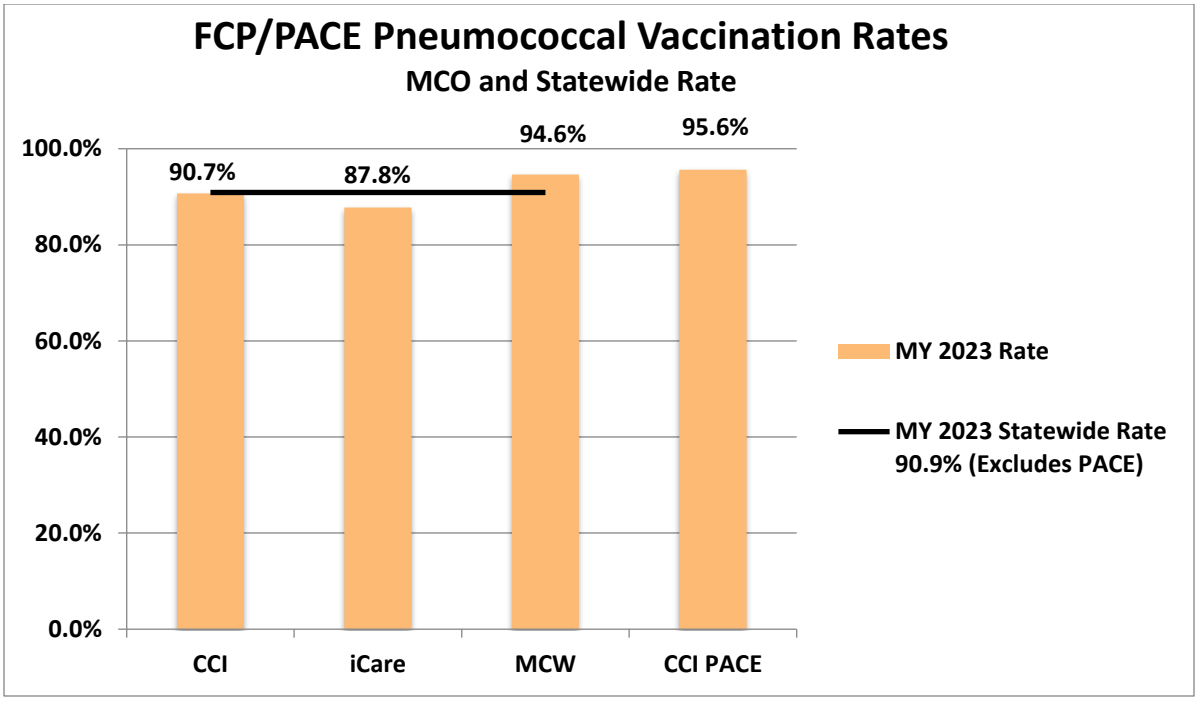
The table on the next page shows pneumococcal vaccination rates by program and MCO for MY 2023 and MY 2022.

Pneumococcal Vaccination Rates by Program and Measurement Year				
Program/MCO	MY 2023			MY 2022
	Eligible Members	Number Vaccinated	Vaccination Rate	Vaccination Rate
Family Care				
CCI	5,474	4,572	83.5%	87.1%
*i*Care	6,470	5,935	91.7%	88.5%
LCI	2,625	2,333	88.9%	90.5%
MCW	6,322	5,765	91.2%	91.7%
Family Care Partnership				
CCI	259	235	90.7%	88.9%
*i*Care	523	459	87.8%	80.6%
MCW	626	592	94.6%	93.7%
PACE				
CCI	411	393	95.6%	95.6%

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



The graph on the next page 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

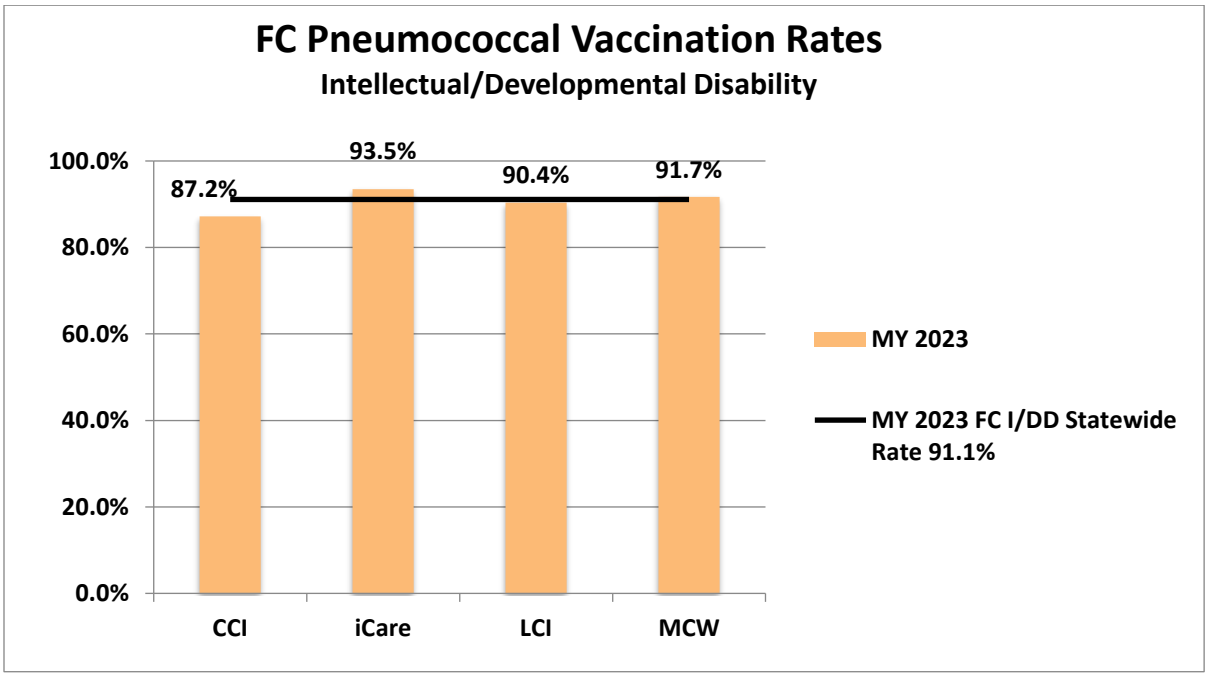
For each program (FC, FCP, and PACE), vaccination rates varied by target group as shown in the table below. All people who have a physical disability (PD) target group and are age 65 or older are assigned to the frail elder (FE) target group. People who are in the intellectual/ developmental disability (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 2023 Pneumococcal Vaccination Rates by Program and Target Group			
Program/Target Group	**Eligible Members**	**Number Vaccinated**	**Vaccination Rate**
Family Care			
Intellectual/Developmental Disability	4,279	3,916	91.1%
Frail Elder	16,594	14,689	88.5%
Family Care Partnership			
Intellectual/Developmental Disability	228	213	93.4%
Frail Elder	748	669	89.4%

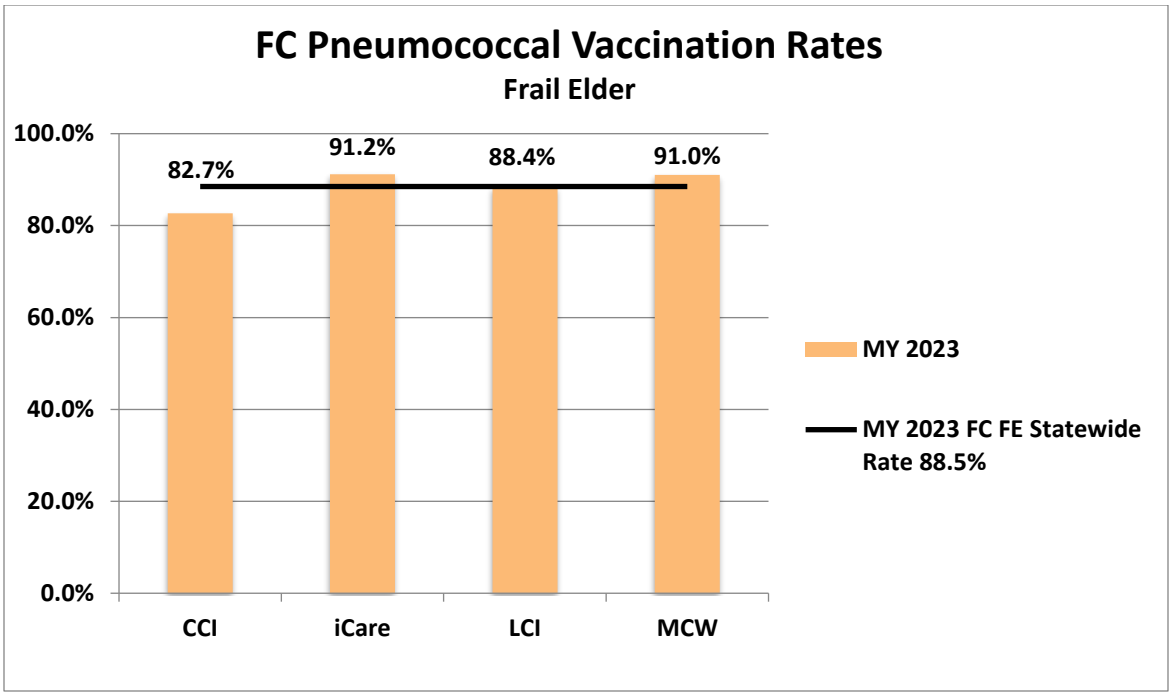
PACE			
Intellectual/Developmental Disability	36	36	100.0%
Frail Elder	375	357	95.2%

Family Care

The graph below shows pneumococcal vaccination rates for FC members in the Intellectual/Developmental Disability target group, by MCO, for MY 2023.

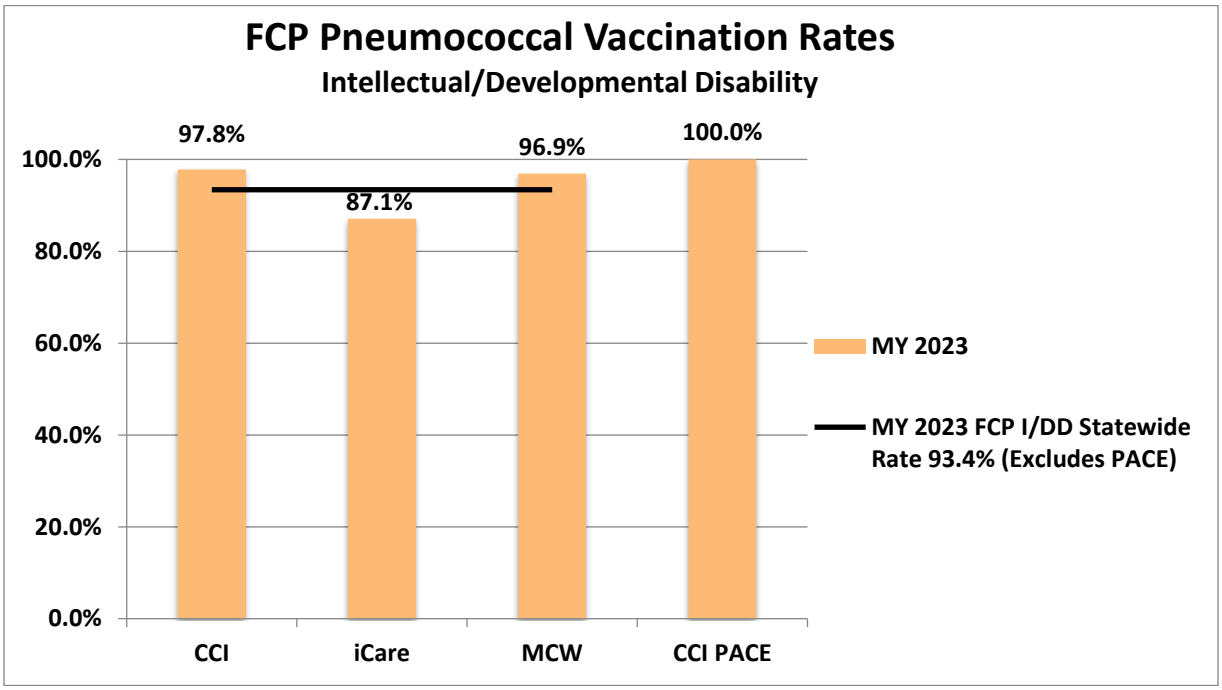


The graph on the next page shows pneumococcal vaccination rates for FC members in the Frail Elder target group, by MCO, for MY 2023.

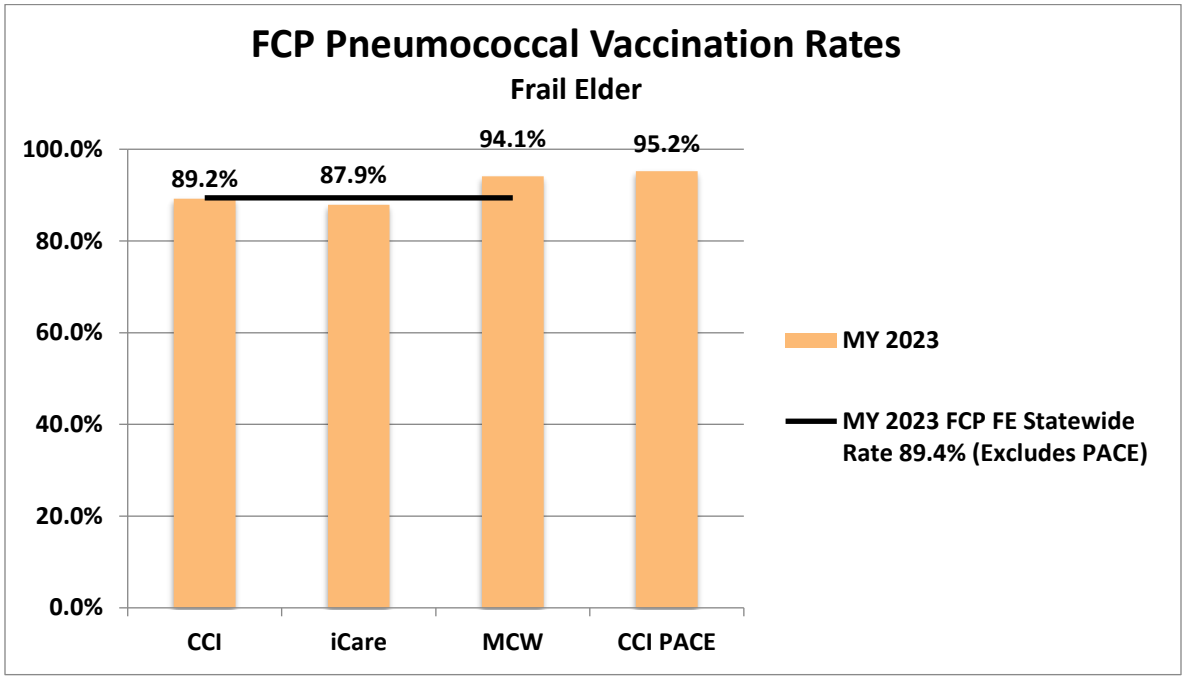


Family Care Partnership/PACE

The graph below shows pneumococcal vaccination rates for FCP and PACE members in the Intellectual/Developmental Disability target group, by MCO, for MY 2023.



The graph below shows pneumococcal vaccination rates for FCP and PACE members in the Frail Elder target group, by MCO, for MY 2023.



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.

Influenza Vaccination: For all MCOs and programs, more than 97 percent of total number of unique members included in the MCOs' and DHS' denominator files were common to both data sets.

Pneumococcal Vaccination: For all MCOs and programs, more than 99 percent of 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 for both quality indicators.

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 2023. 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 2023. 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 2023 were not biased, meaning the rates can be accurately reported.

The overall findings for the *Quality Indicator: Pneumococcal Vaccination* for MY 2023 were not biased, meaning the rates can be accurately reported.

The overall findings from MY 2022 are included for informational purposes.

Vaccination Record Validation Aggregate Results

MY 2023 Influenza and Pneumococcal Vaccination Record Validation				
Quality Indicator	**Total Records Reviewed**	**Number Valid**	**Percentage Valid**	**T-Test Result**
Influenza Vaccinations	240	238	99.2%	Unbiased
Pneumococcal Vaccinations	240	240	100.0%	Unbiased
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

Vaccination Record Validation Individual MCO Results

The following tables provide information about the validation findings for each MCO in MY 2023.

Results for Influenza Vaccination

MY 2023 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
*i*Care	30	30	100.0%	Unbiased
LCI	30	29	96.7%	Unbiased
MCW	30	30	100.0%	Unbiased
Family Care Partnership				
CCI	30	29	96.7%	Unbiased
*i*Care	30	30	100.0%	Unbiased
MCW	30	30	100.0%	Unbiased
PACE				
CCI	30	30	100.0%	Unbiased

Results for Pneumococcal Vaccination

MY 2023 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
*i*Care	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. The policies are to include guidance for identifying and documenting vaccination outcomes, such as received, refused, or contraindicated. Several MCO's did not

include information specific to Coronavirus Disease-2019 (COVID-19) in their influenza vaccination policies and procedures. MetaStar recommends those MCOs update policies and procedures accordingly.

Progress on Previous EQRO Plan Level Recommendations

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

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

The table below identifies the recommendations made the by the EQRO in the prior review, FY 22-23, the actions taken by the MCO to address the recommendations, and the degree to which the MCO addressed the recommendations.

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCI	– Conduct a root cause analysis for the influenza vaccination rates that declined from MY 2021. 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.	– No progress was identified.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Update policies, procedures, and staff and member educational materials to reflect coadministration 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.*		
*i*Care	– Conduct a root cause analysis for the influenza and pneumococcal vaccination rates that declined from MY 2021. 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 coadministration of the influenza and Coronavirus Disease 2019 (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	– The MCO's pneumococcal vaccination rate demonstrated statistically significant improvement in MY 2023 from MY 2022.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	DHS implemented the target group automation for the *Adult Long Term Care Functional Screen* in early 2017.		
Inclusa	– Conduct a root cause analysis for the influenza and pneumococcal vaccination rates that declined from MY 2021. 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.	– The MCO's pneumococcal vaccination rates demonstrated statistically significant improvement in MY 2023 from MY 2022.	Low
LCI	– Conduct a root cause analysis for the pneumococcal vaccination rate that declined from MY 2021. 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 Coronavirus Disease 2019 (COVID-19) not being an exclusion from receiving the influenza vaccine.	– No progress was identified.	Low
MCW	– Conduct a root cause analysis for the Family Care and Family Care Partnership influenza vaccination rate that declined from MY 2021. The rate declined for a third consecutive year in both programs.	– No progress was identified.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	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.		

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 organization related to quality, timeliness, and access to services, including health care and long term services and supports (LTSS).

The Department of Health Services (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 Home and Community Based Services (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 second year of the cycle; therefore, QAPI and Grievance Systems standards were reviewed. The combined compliance score of all standards is presented in the *Overall Results* section of this report and includes all standards reviewed in the two-year cycle, Review Cycle Fiscal Year 2022-2023 (FY 22-23)/Fiscal Year 2023-2024 (FY 23-24). The following MCOs and programs were evaluated:

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, Inc. (MCW)	FC; FCP

Overall QCR Results

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.

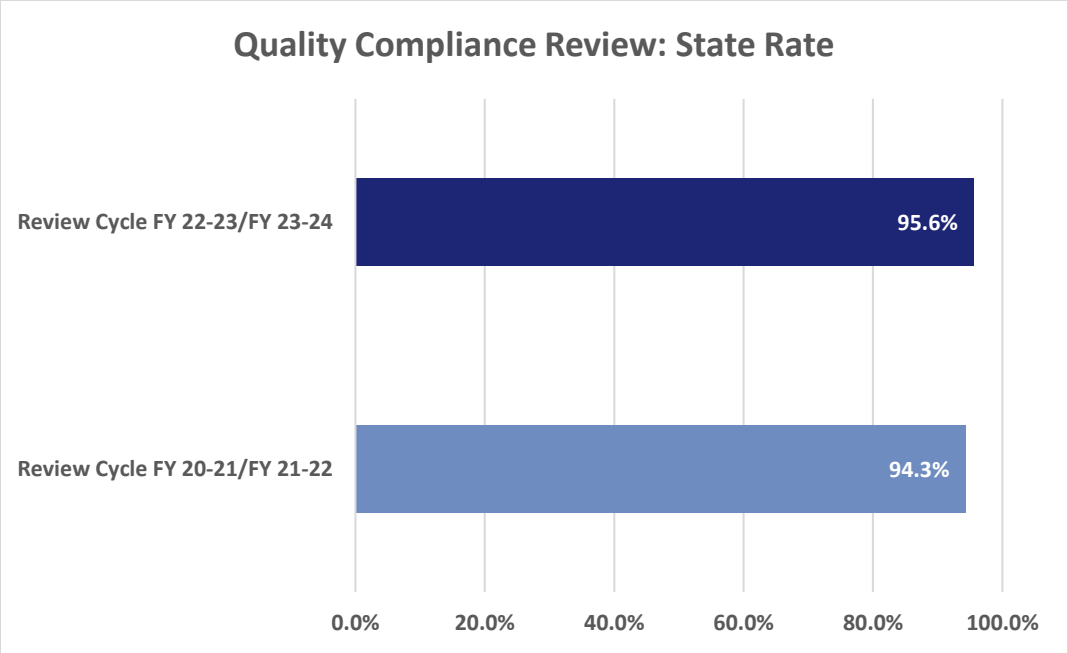
Scoring Legend		
Percentage Met	**Stars**	**Rating**
95.0% - 100.0%	★★★★★	Fully Met
90.0% - 94.9%	★★★★½	
85.0% - 89.9%	★★★★	Substantially Met
80.0% - 84.5%	★★★½	

Scoring Legend		
Percentage Met	**Stars**	**Rating**
75.0% - 79.9%	★★★	Partially Met
70.0% - 74.9%	★★½	
65.0% - 69.9%	★★	Minimally Met
60.0% - 64.9%	★½	
55.0%-59.9%	★	Not Met
< 55.0%	½	

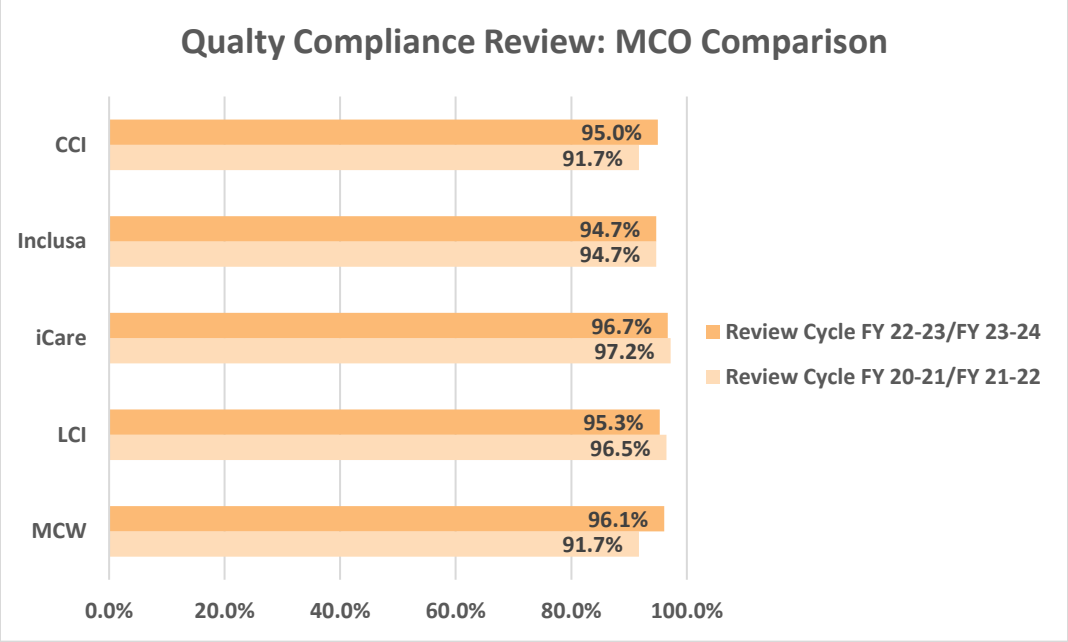
For all MCOs, the statewide compliance score is 95.6 percent, and a star rating of Fully Met. The score is based on the review of the MCO Standards in FY 22-23 and the QAPI and Grievances Systems standards in FY 23-24, which make up Review Cycle FY 22-23/FY 23-24. The table below indicates the State's overall level of compliance with all standards

Quality Compliance Review Cycle FY 22-23/FY 23-24				
Focus Area	**Scoring Elements**	**Percentage**	**Stars**	**Rating**
MCO Standards: Provider Network, Care Management, and Enrollee Rights	545/569	95.8%	★★★★★	Fully Met
QAPI	84/90	93.3%	★★★★½	Fully Met
Grievance Systems	214/223	96.0%	★★★★★	Fully Met
Overall	**843/882**	**95.6%**	★★★★★	**Fully Met**

The graph on the next page illustrates the State's overall compliance with standards reviewed in Review Cycle FY 22-23/FY 23-24 and compares the score to the standards reviewed in Review Cycle FY 20-21/FY 21-22.



The graph below illustrates each MCOs' overall compliance with the standards reviewed in Review Cycle FY 22-23/FY 23-24 and compares the score to the standards reviewed in Review Cycle FY 20-21/FY 21-22.



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.

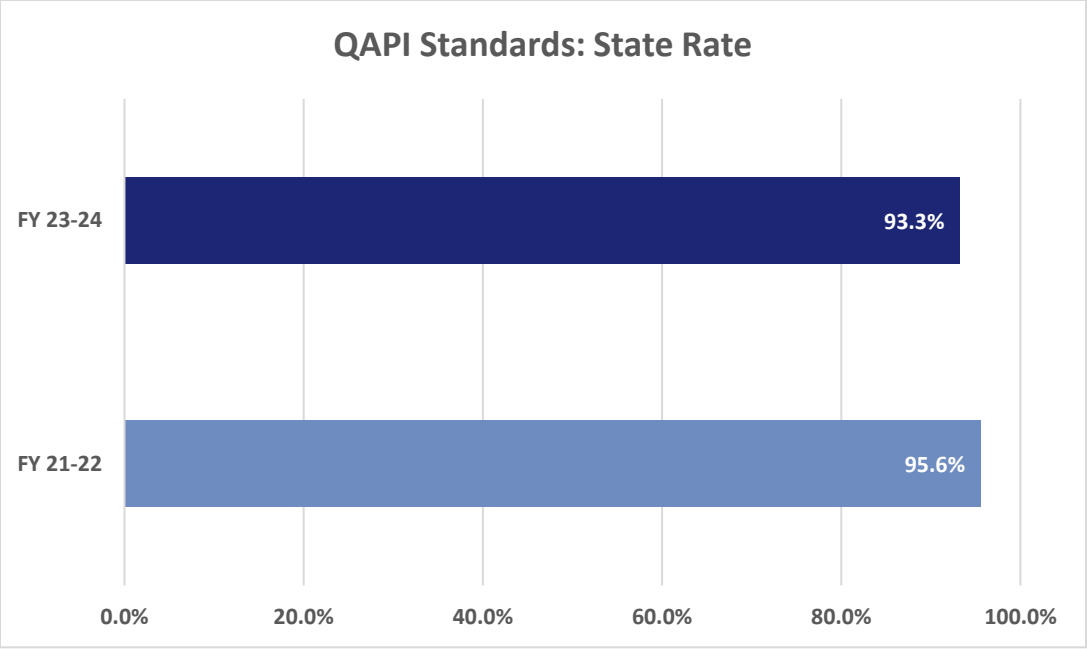
Observation and Analysis: QAPI Standards

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

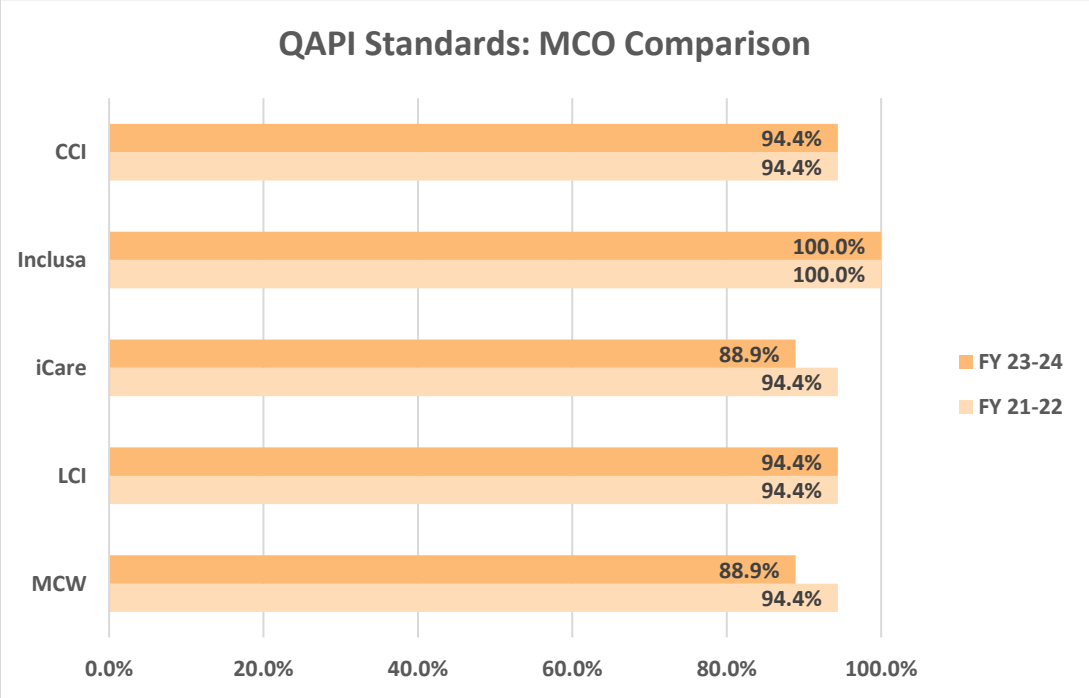
Quality Assessment and Performance Improvement Standards FY 23-24				
Standard	**Scoring Elements**	**Percentage**	**Stars**	**Rating**
Q1	38/40	95.0%	★★★★★	Fully Met
Q2	36/40	90.0%	★★★★½	Fully Met
Q3*	NA	NA	NA	NA
Q4*	NA	NA	NA	NA
Q5	10/10	100.0%	★★★★★	Fully Met
Overall	**84/90**	**93.3%**	★★★★½	**Fully Met**

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

The graph on the next page illustrates the State's overall compliance with this focus area in FY 23-24 and compares the score to the same focus area reviewed in FY 21-22.



The graph below illustrates each MCOs' overall compliance with this focus area in FY 23-24 and compares the score to the same focus area reviewed in FY 21-22.



Q1 General rules - 42 CFR 438.330(a)

The MCOs' quality management program shall be administered through clear and appropriate structures, and include member, staff, and provider participation. The standard, Q1, contains eight scoring elements. Collectively, the MCOs satisfied requirements for 38 out of 40 scoring elements, for a score of 95.0 percent, and a star rating of Fully Met.

Overall, the MCOs demonstrated compliance with this standard. The MCOs showed they have quality management programs that facilitate participation from members, staff, and providers. This was evidenced through various quality and improvement committee meeting minutes as well the interview sessions with MCO staff.

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

The MCOs shall maintain documentation and monitoring of the required activities of the Quality Management program. The standard, Q2, contains eight scoring elements. Collectively, the MCOs satisfied requirements for 36 out of 40 scoring elements, for a score of 90.0 percent, and a star rating of Fully Met.

Documents submitted by the MCOs, as well as interview sessions with staff, confirm processes for maintaining documentation and monitoring quality management program activities. Requirements for the documentation of the quality management activities, findings, and results include:

- The annual review and evaluation of the quality management work plan and its approval by the governing board;
- Monitoring the completeness and quality of functional screens;
- Monitoring the member's long-term care and personal experience outcomes;
- Member satisfaction surveys;
- Provider surveys;
- Incident management systems;
- Appeals and grievances that were resolved as requested by the member;
- Monitoring the quality and standards of sub-contracted services, including access to providers and verification that services were provided;
- Monitoring the use of restrictive measures through policies and procedures;
- Performance improvement projects;

- Monitoring care management practices, such as the quality of assessments, member-centered plans, and practices related to the support of vulnerable high-risk members; and
- Monitoring to detect under and over utilization of services.

Scoring element Q2.2 required the MCOs to monitor the quality of care management practices. All of the MCOs demonstrated the ability to monitor these practices through various mechanisms in place; however, MCW and CCI did not use adequate sample sizes for their internal file review process for the FCP and PACE programs, respectively. LCI did not demonstrate specific monitoring to assure members are afforded choice among covered services and providers. Additionally, MCW did not include monitoring for member and legal decision maker inclusion in the care planning process, or monitoring for appropriate service delivery. MetaStar recommends that MCOs ensure sample sizes used for internal file review processes are appropriate, and that MCOs implement monitoring specific to member choice, and monitoring of the inclusion of members and legal decision makers in the care planning process.

Q3 Performance measurement - 42 CFR 438.330(c)

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

Q4 Performance improvement projects - 42 CFR 438.330(d)

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

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

The MCOs create and evaluate the quality work plan annually. The standard, Q5, contains two 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 Fully Met.

All MCOs' quality management plans and evaluations met requirements of this standard. The MCOs each had quality management plans that outlined the scope of activity, as well as goals, objectives, timelines, and a responsible person for the work plan during the contract period. The plans all contained evidence of the MCOs' commitment of adequate resources to carry out these programs. The MCOs also provided documentation showing that they evaluate the overall effectiveness, including the impact of their quality management programs annually, in

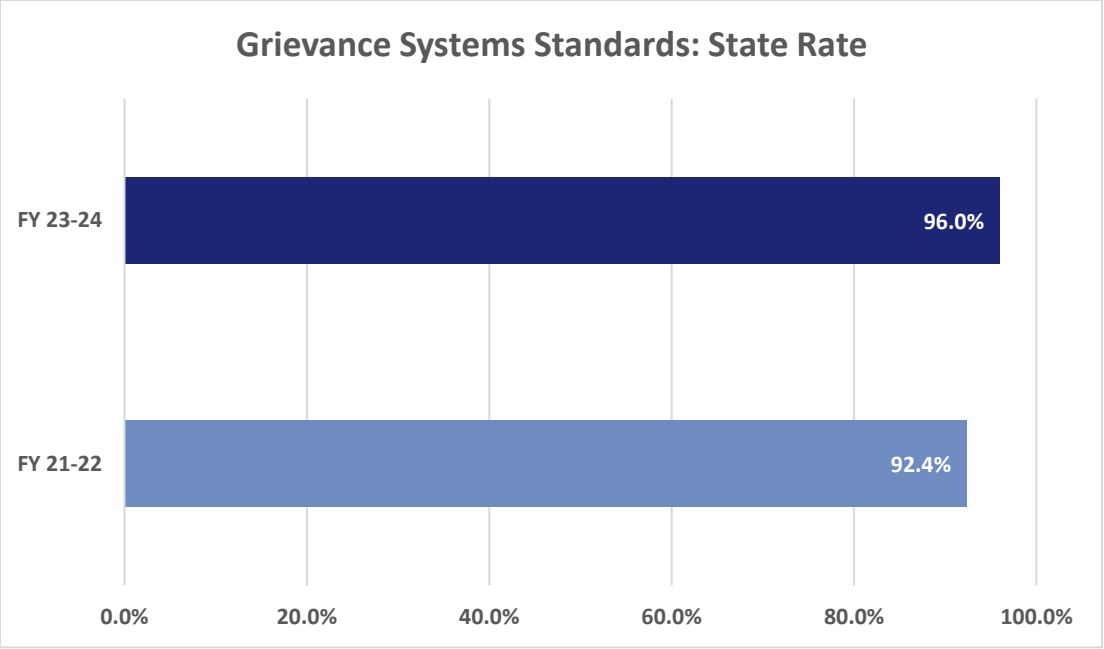
order to determine whether the programs have achieved significant improvements, where needed, in the quality of service provided to their members.

Observation and Analysis: Grievance Systems

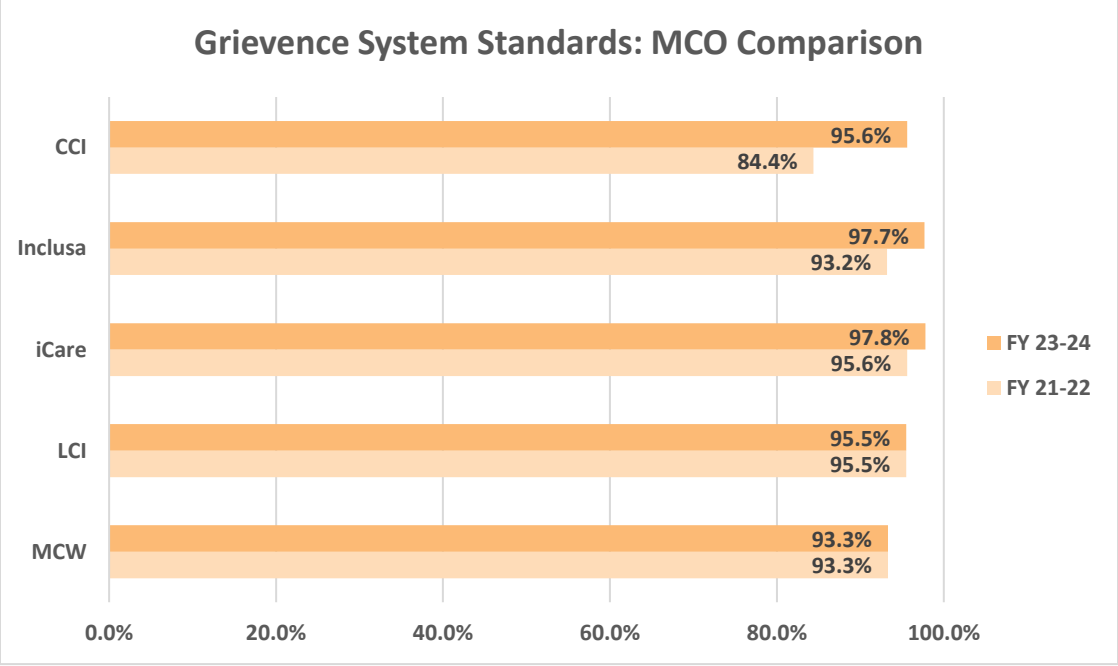
MCOs are required to maintain a grievance system that provides members the ability to grieve or appeal actions of the organization, and provide access to the State's Fair Hearing system. Ten standards address the requirements related to the required grievance systems. The table below indicates the MCO's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

Grievance Systems Standards FY 23-24				
Standard	**Scoring Elements**	**Percentage**	**Stars**	**Rating**
G1	20/20	100.0%	★★★★★	Fully Met
G2	35/35	100.0%	★★★★★	Fully Met
G3	13/20	65.0%	★★	Minimally Met
G4	44/45	97.8%	★★★★★	Fully Met
G5	34/35	97.1%	★★★★★	Fully Met
G6	20/20	100.0%	★★★★★	Fully Met
G7	10/10	100.0%	★★★★★	Fully Met
G8	5/5	100.0%	★★★★★	Fully Met
G9	20/20	100.0%	★★★★★	Fully Met
G10	13/13	100.0%	★★★★★	Fully Met
Overall	**214/223**	**96.0%**	★★★★★	**Fully Met**

The graph on the next page illustrates the State's overall compliance with this focus area in FY 23-24 and compares the score to the same focus area reviewed in FY 21-22.



The graph below illustrates each MCOs' overall compliance with this focus area in FY 23-24 and compares the score to the same focus area reviewed in FY 21-22.



G1 Grievance systems - 42 CFR 438.228

Each MCO must have a grievance and appeal system in place that includes an internal grievance process, an appeal process, and access to the State's Fair Hearing system. The standard, G1, contains four 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 Fully Met.

A review of policy and procedure documents, as well as the staff interview sessions, showed grievance systems were in place for all MCOs, and that all MCOs met the requirements of this standard.

G2 General requirements - 42 CFR 438.402

The MCOs must adhere to requirements for the member's authority, process, and timing to file grievances and appeals. The standard, G2, contains seven scoring elements. Collectively, the MCOs satisfied requirements for 35 out of 35 scoring elements, for a score of 100.0 percent, and a star rating of Fully Met.

Document review and interviews with MCO staff confirmed the use of policies to ensure the appropriate individuals have the authority to file a grievance or appeal, and for all processes and timeframes to be adhered to. Scoring elements related to filing grievances and appeals were validated through a verification activity conducted by MetaStar for each MCO. The verification activity included a random sample of each MCOs' local appeals and grievances.

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

The MCOs must comply with content requirements and timing of *Notices of Adverse Benefit Determination*. The standard, G3, contains four scoring elements. Collectively, the MCOs satisfied requirements for 13 out of 20 scoring elements, for a score of 65.0 percent, and a star rating of Minimally Met.

Document review shows that all MCOs have policy and procedure documents in place that govern when written notices of an adverse benefit determination, or the written notification of appeal and grievance rights are needed. The staff interviews confirmed that MCO staff are informed of these policies and procedures, and are aware of timeframes associated with these notices.

Scoring element G3.2 required that MCOs use DHS and/or CMS issued *Notice of Adverse Benefit Determination* forms. The document review and verification activity confirmed CCI and MCW used an incorrect version of some of these forms. CCI was also using some forms that did not

include the document identification number and version date in the footer of the document, which is needed to confirm the use of correct and current versions. MetaStar recommends these MCOs focus efforts to ensure the current and accurate notice of adverse benefit forms are being used.

Scoring element G3.3 required the MCOs to mail or hand deliver the *Notice of Adverse Benefit Determination* letter as expeditiously as the member's condition requires and within the required timeframes. Results from MetaStar's Care Management Review (CMR) and the MCOs' internal monitoring data are used in the evaluation of this scoring element. All five MCOs indicated a need for improvement in this area. MetaStar recommends the MCOs focus efforts on improving the timeliness of issuing a *Notice of Adverse Benefit Determination*, and specifically the recognition of when notices are indicated.

G4 Handling of grievances and appeals - 42 CFR 438.406

The MCOs must comply with requirements for handling of grievances and appeals, including acknowledgement, local committee composition and requirements, and special requirements for appeals. The standard, G4, contains nine scoring elements. Collectively, the MCOs satisfied requirements for 44 out of 45 scoring elements, for a score of 97.8 percent, and a star rating of Fully Met.

The document review and interview sessions verified that each MCO has Member Rights Specialists (MRS) who collaborate with IDT staff to support members as needed, for grievances and appeals. Several scoring elements related to these requirements were validated through the verification activity conducted by MetaStar.

G5 Resolution and notification - 42 CFR 438.408

The MCOs must comply with requirements for the resolution and notification requirements for grievances and appeals. The standard, G5, contains seven scoring elements. Collectively, the MCOs satisfied requirements for 34 out of 35 scoring elements, for a score of 97.1 percent, and a star rating of Fully Met.

Document review and interviews with MCO staff were used to confirm compliance with this standard. Several scoring elements related to resolution and notification requirements were validated through the verification activity. Overall, the MCOs demonstrated sufficient practices related to the standard timeframes for resolution and notification of grievances and appeals.

G6 Expedited resolution of appeals - 42 CFR 438.410

The MCOs must comply with requirements for an expedited review process for appeals. The standard, G6, contains four 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 Fully Met.

Review of policy and procedure document submissions, along with the staff interviews, confirmed compliance with this standard for all MCOs.

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

The MCOs must provide information about the grievance and appeal system to providers and subcontractors. The standard, G7, contains two 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 Fully Met.

The MCOs evidenced provider handbooks and/or subcontracts that included all required information. This information is given to providers when they enter into a contract with each MCO.

G8 Record keeping requirements - 42 CFR 438.416

The MCOs must comply with record keeping requirements for grievances and appeals. The standard, G8, contains one scoring element. Collectively, the MCOs satisfied requirements for five out of five scoring elements, for a score of 100.0 percent, and a star rating of Fully Met.

All MCOs submitted policy and procedure documents that included all of the record keeping requirements for grievances and appeals. Interviews with MCO staff indicated the MRS' utilize various monitoring tools and logs to ensure record keeping requirements are met.

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

The MCOs must comply with requirements for continuation of benefits, duration, and member responsibility for costs. The standard, G9, contains four 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 Fully Met.

Document submission and interviews with MCO staff confirmed compliance with this standard for all MCOs. Each MCO allows members to continue services through the local MCO appeal process and the State's Fair Hearing process when the applicable criteria are met.

G10 Effectuation of reversed appeal resolution - 42 CFR 438.424

The MCOs must comply with requirements to reinstate benefits for reversed denials. The standard, G10, contains two scoring elements for MCOs operating FC and three scoring elements for MCO operating FCP and PACE. Collectively, the MCOs satisfied requirements for 13 out of 13 scoring elements, for a score of 100.0 percent, and a star rating of Fully Met.

Document submission and interviews with MCO staff confirmed compliance with this standard for all MCOs.

Progress on Previous EQRO Plan Level Recommendations

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

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

The table below identifies the recommendations made the by the EQRO in the prior review of the standards conducted in FY 21-22, the actions taken by the MCO to address the recommendations, and the degree to which the MCO addressed the recommendations.

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCI	– Implement specific monitoring for the quality of care management to include members being afforded choice among covered services and providers. – Improve the timeliness of issuing notices when indicated by focusing on identifying the need for a decision on a service request, as	– The MCO consistently documented attempts to resolve grievances and appeals through internal review, negotiation, and/or mediation. – The MCO improved the timeliness of issuing written notifications to members on decisions to extend the timeframes for appeal resolutions, and appropriately	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	well as sending notices when services are reduced or terminated. – Ensure attempts to resolve grievances and appeals through internal review, negotiation, or mediation is consistently documented. – Focus efforts on improving the timeliness of issuing written notifications to members on decisions to extend the timeframe for appeal resolutions, or appropriately document if the extension request was member initiated and a notification is not required. – Update the organization's Program of All-Inclusive Care for the Elderly (PACE) appeal policy to include the timeframe the MCO has to provide a decision on expedited appeals request as outlined in the DHS-MCO contract. – Update the organization's grievance and appeal policies and procedures to include the requirement that no punitive action is taken against a provider who requests or supports a member's request for an appeal or grievance. – Update the organization's Family Care Partnership (FCP) appeal policy to include the timeframe the member has to request a State Fair Hearing as outlined in the DHS-MCO contract. – Update the organization's Family Care Partnership (FCP) appeal policy to include the criteria a member does not have the right to	documented if extension requests were initiated by the member. – The MCO updated the appeal policy for PACE to include the timeframe to provide a decision on expedited appeal requests. – The MCO updated the grievance and appeal policies and procedures to include the requirement that no punitive action is taken against a provider who requests or supports a member's request for an appeal or grievance. – The MCO updated the FCP appeal policy to include the timeframe the member has to request a State Fair Hearing. – The MCO updated the FCP appeal policy to include the criteria when a member does not have the right to continue benefits during an appeal or State Fair Hearing.	

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– continue benefits during an appeal or State Fair Hearing as outlined in the DHS-MCO contract.		
*i*Care	– Implement specific monitoring for the quality of care management to include members being afforded choice among covered services and providers. – Enhance internal file review guidance to ensure all required monitoring activities are accounted for. – Ensure monitoring systems include mechanisms to identify and analyze notices that are indicated, but not issued. – Ensure member grievances not resolved to the members' satisfaction are heard by the managed care organization's local grievance and appeal committee.	– The MCO implemented internal file review monitoring to include members being afforded choice among covered services and providers. – The MCO implemented a process to ensure grievances not resolved to the members' satisfaction are being heard by the managed care organization's local grievance and appeal committee.	Low
Inclusa	– Update written guidance to include the requirement that financial eligibility decisions and cost share calculations can only be contested through the State Fair Hearing process, and cannot be reviewed by the MCO's internal appeal system. – Focus efforts on improving issuing timely *Notice of Adverse Benefit Determination* forms to members when indicated. – Update written guidance and letter template language for when a request for an expedited resolution is denied to include the member's right to file a grievance if the	– The MCO updated written guidance to include the requirement that financial eligibility decisions and cost share calculations can only be contested through the State Fair Hearing process, and cannot be reviewed by the MCO's internal appeal system. – The MCO updated written guidance and letter template language for instances when a request for an expedited resolution is denied to include the member's right to file a grievance if the member disagrees with the decision.	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– member disagrees with the decision.		
LCI	– Implement specific monitoring for the quality of care management to include members being afforded choice among covered services and providers. – Continue efforts to improve the issuing of notices timely when indicated. – Develop systems to identify and track the organization's date of determining an extension is needed for an appeal or grievance, to ensure that the written notice to the member is issued within two calendar days.	– No progress was identified.	Low
MCW	– Implement specific monitoring for the quality of care management to include members being afforded choice among covered services and providers. – Ensure the appeal process reflects the current requirements throughout the policy. – Focus efforts on improving the timeliness of issuing a *Notice of Adverse Benefit Determination* when indicated. – Implement a systematic approach to tracking informal resolution attempts of member appeals and grievances.	– The MCO implemented specific monitoring for the quality of care management to include members being afforded choice among covered services and providers. – The MCO's appeal process requirements were consistent in all appeal and grievance policies. – The organization implemented a systematic approach to informal resolutions attempts of member appeals and grievances.	Medium

Conclusions

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

Protocol 4: Validation of Network Adequacy

Validation of Network Adequacy, or Network Adequacy Validation (NAV), is a mandatory activity, identified in 42 CFR 438.68. The review assesses the capabilities of each managed care organization's provider network to ensure each are sufficient to provide timely and accessible care to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries across the continuum of services. 42 CFR 438.68 requires states to set quantitative network adequacy standards that account for regional factors and the needs of the state's managed care programs populations. This is a new protocol, implemented in fiscal year 2023-2024 (FY 23-24).

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

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

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

Network adequacy standards are included by reference in the 2023 Department of Health Service (DHS)-Managed Care Organization (MCO) contracts for Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly (PACE). The standards can be found in the *Managed Care Organization (MCO) Provider Network Adequacy* P-02542 document available at the following website:
Managed Care Organization (MCO) Provider Network Adequacy Policy (wisconsin.gov)

Providers of 1915(c) Home and Community Based Services (HCBS) waiver services and supports or Family Care long-term state plan services and supports are included in this analysis. The service types that contain a target for provider to member ratios were included. The wait time to receive service will be analyzed in future measurement periods. Please see Appendix 4 for the list of service types meeting the member to provider ratios.

The following MCOs and programs were included in the review:

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, Inc. (MCW)	FC; FCP

Overall NAV Results

Key findings from the validation of network adequacy discussed in this report are summarized below. Additional information can be found in the sections below. The review was implemented in FY 23-24 and aligns with the protocol, which defines the review activity.

Review Activity	FY 23-24 Results	Prior Review Results
Protocol 4: Validation of Network Adequacy	Data Collection Procedures: Requirements Met Network Adequacy Methods: Requirements Met Network Adequacy Results: 97.4%	Protocol 4 was implemented in FY 23-24; therefore, there are no prior results for comparison

Data Collection Procedures

Policies and procedures were submitted by each MCO related to member enrollment and disenrollment as well as provider onboarding and off boarding. No findings were identified.

Network Adequacy Methods

Policies and procedures were submitted by the MCO related to member and provider data maintenance. No findings were identified.

Network Adequacy Results

Compliance with NAV requirements is expressed in terms of a percentage of network adequacy standards met and validation rating, as identified in the table below.

Network Adequacy Validation Score	
Percentage Met	**Validation Rating**
90.0% – 100.0%	High Confidence
50.0% – 89.9%	Moderate Confidence
10.0% – 49.9%	Low Confidence
0.0% – 9.9%	No Confidence

Findings are reflective of the state's compliance with requirements for the programs identified in this report, and are reported separately by program type.

Network Adequacy Validation Results			
Review	**Program**	**Percentage Met**	**Validation Rating**
ISCA	FC, FCP, PACE	99.6%	High Confidence
Member to Provider Ratio	FC	94.5%	High Confidence
	FCP	98.4%	High Confidence
	PACE	99.2%	High Confidence
Provider Directory	FC	92.7%	High Confidence
	FCP	98.4%	High Confidence
	PACE	99.2%	High Confidence
Overall	FC, FCP, PACE	97.4%	High Confidence

ISCA Review

No findings of deficiency were identified during the review of the ISCAs.

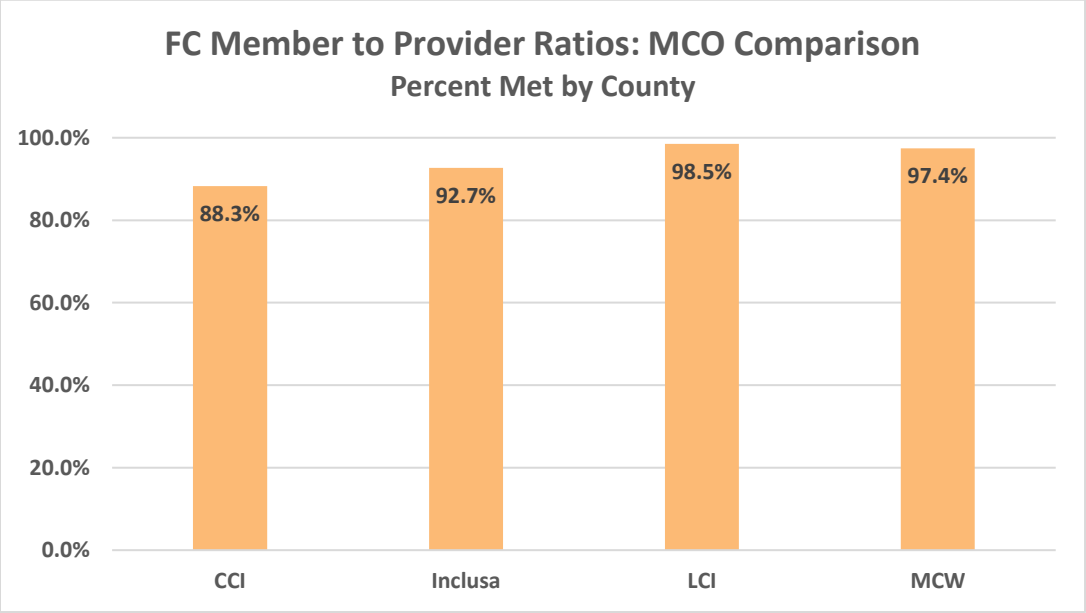
Member to Provider Ratios Statewide

The table below shows the percentage of counties across all service types that met the member to provider ratio in each program. Please see the Appendix 4 for the list of service types meeting member to provider ratios.

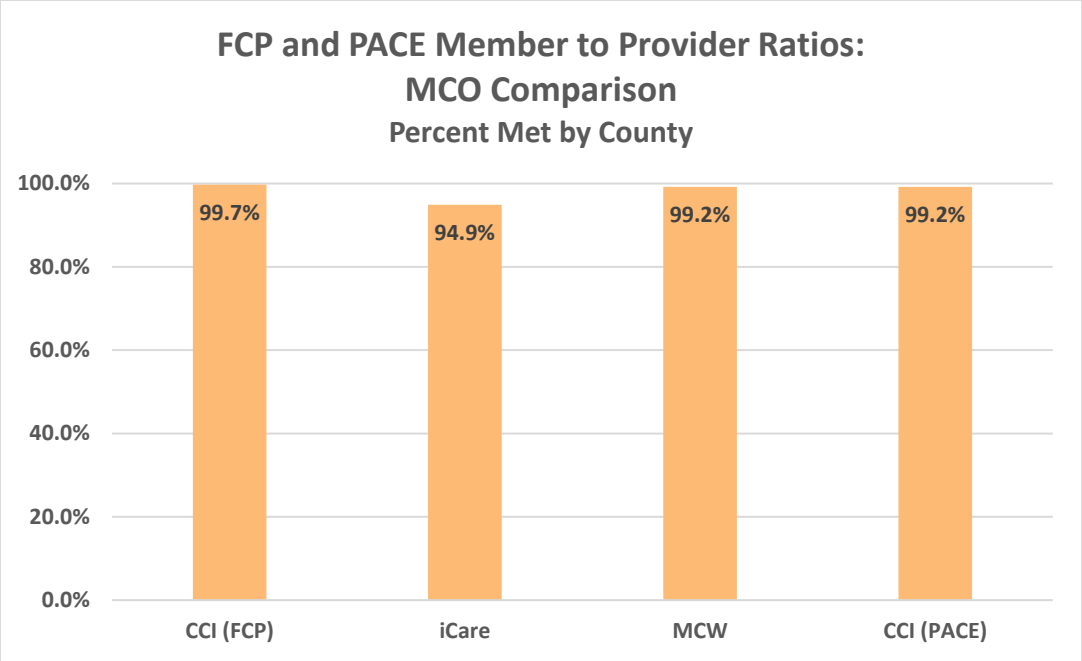
Member to Provider Ratios Met by County	
Program	**Percent of Counties**
FC	94.5%

Member to Provider Ratios Met by County	
Program	**Percent of Counties**
FCP	98.4%
PACE	99.2%

The graph below compares the percentage of counties meeting the member to provider ratio for each MCO operating the FC program.



The following graph compares the percentage of counties meeting the member to provider ratio for each MCO operating the FCP and PACE program. Only one MCO operates the PACE program.

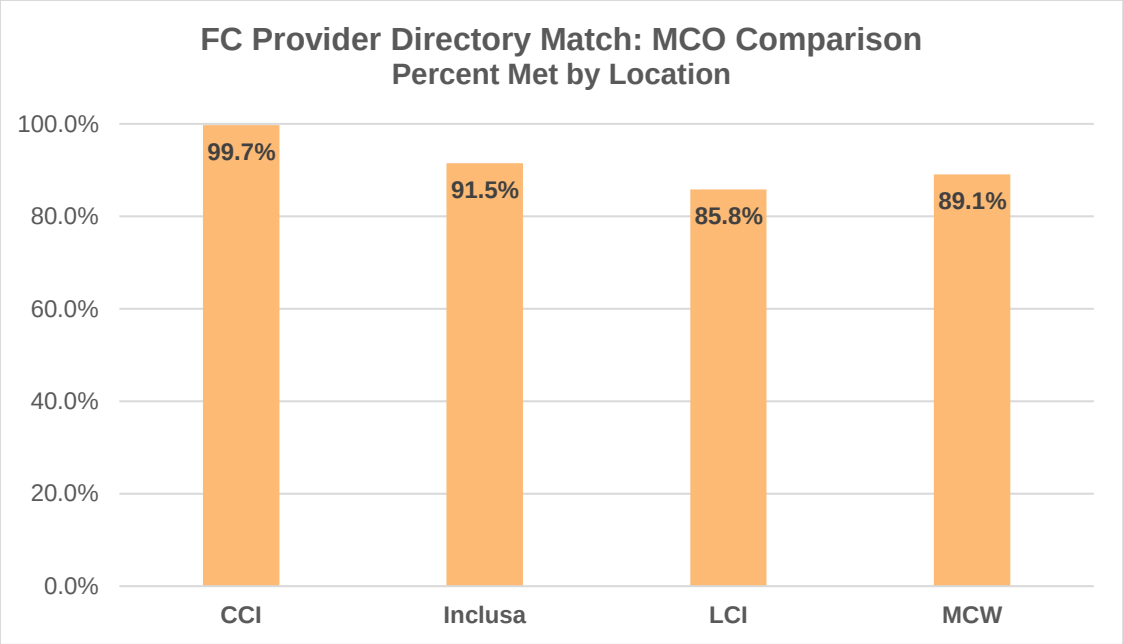


Provider Directory Statewide

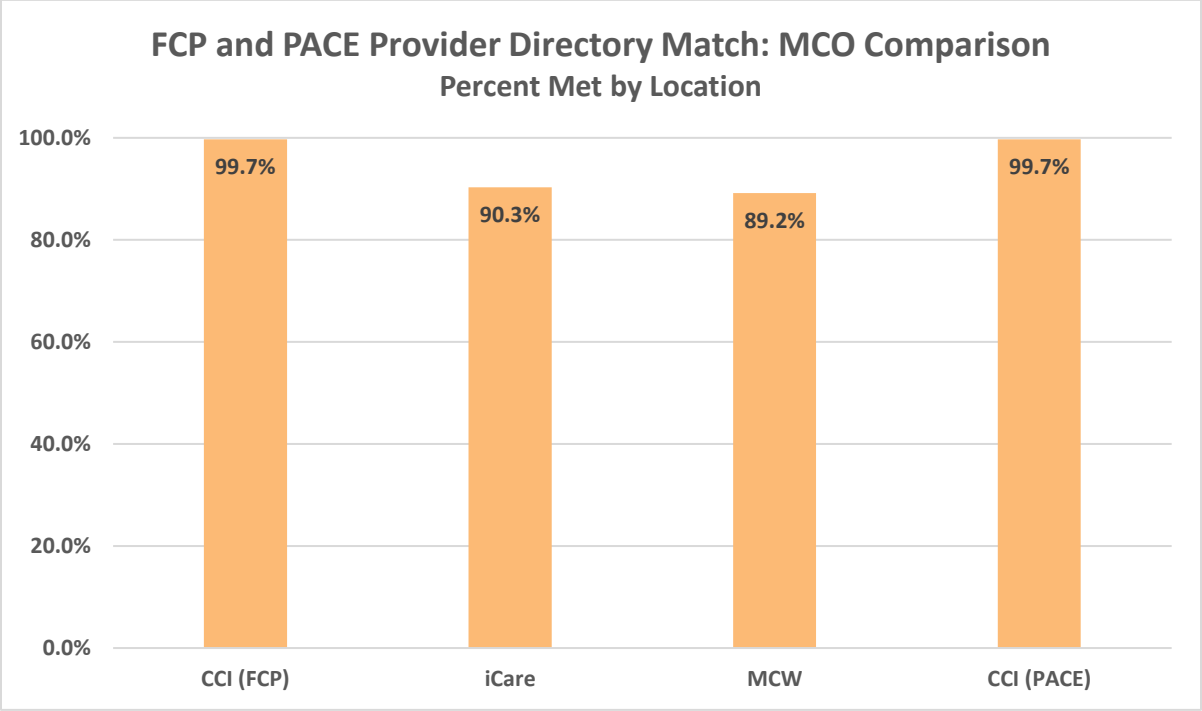
The table below shows the percentage of locations that matched between the MCOs' provider extracts and provider directories in each program. Please see Appendix 5 for a list of service types and location matches.

Provider Directory Location Match	
Program	**Percent of Locations**
FC	92.7%
FCP	92.6%
PACE	99.7%

The graph on the next page compares the percentage of locations that matched between the MCOs' provider extracts and the provider directories for each MCO operating the FC program.



The graph below compares the percentage of locations that matched between the MCOs' provider extracts and the provider directories for each MCO operating the FCP and PACE program. Only one MCO operates the PACE program.



Results for each Validation of Network Adequacy Focus Area

Each section that follows provides a brief explanation of a NAV focus area reviewed this fiscal year, including rationale for any areas the MCO is not fully compliant.

Observation and Analysis: Data Collection Procedures

The initial data request was sent to each MCO in April 2024. The MCOs submitted extracts from their provider and member systems, the provider directory, and policies and procedures related to provider and member management.

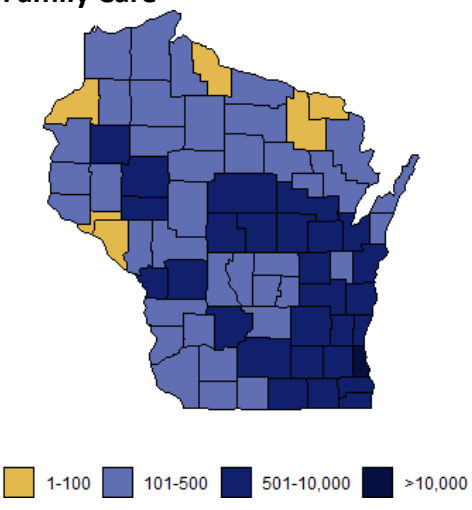
The network adequacy standards for medical providers under Family Care Partnership and PACE are under development. A revised data request was sent to the MCOs in May 2024 removing the requirement to include medical providers for these programs. These providers will be analyzed in a future measurement period.

Observation and Analysis: Network Adequacy Methods

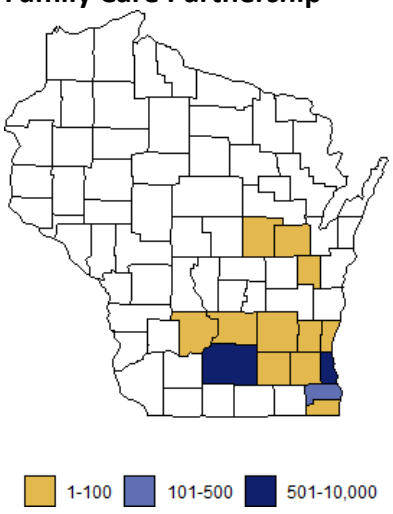
The provider network was analyzed using each MCOs' provider and member extracts. Members were excluded from the analysis if they resided outside of the MCO and program's geographic service area. Below are maps showing the distribution of members by program as well as the top service types that did not meet network adequacy targets.

All Members with Wisconsin Residence

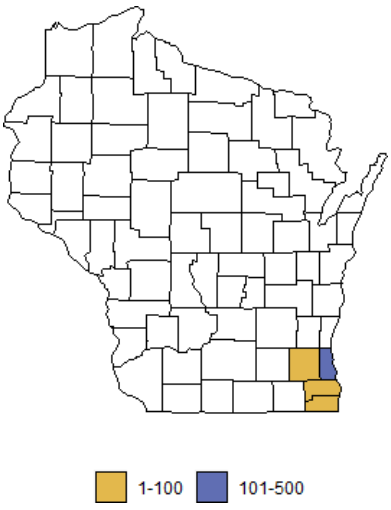
Family Care



Family Care Partnership



PACE

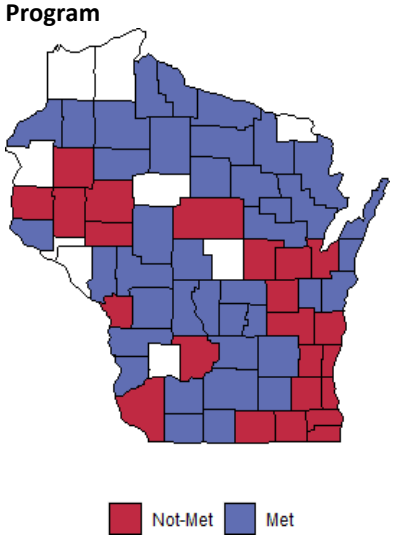


Provider Service Types - Top 3 Service Types Not Meeting Target by Program

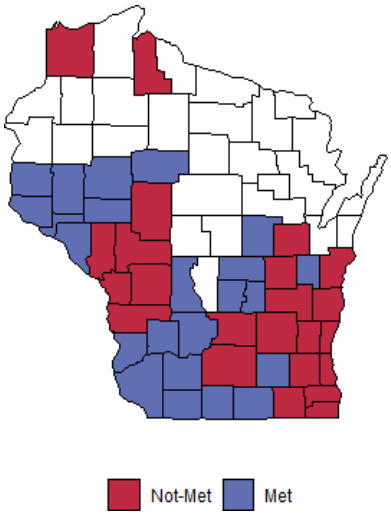
The "Not-Met" counties in the maps below are those where at least one MCO did not meet the service type target.

Family Care

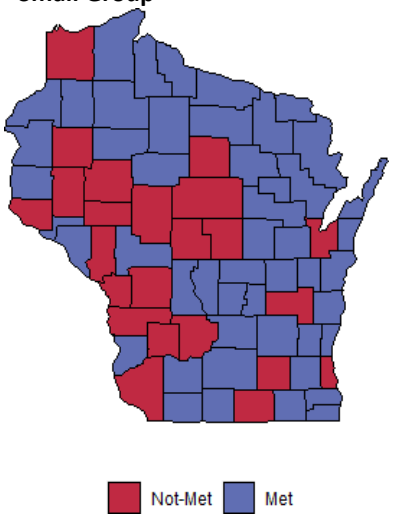
1 (Tie) Community Support Program



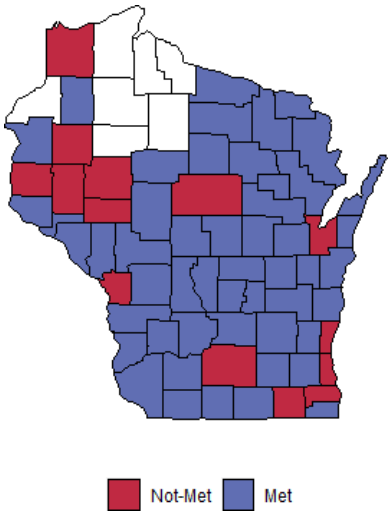
1 (Tie) Mental Health Day Treatment



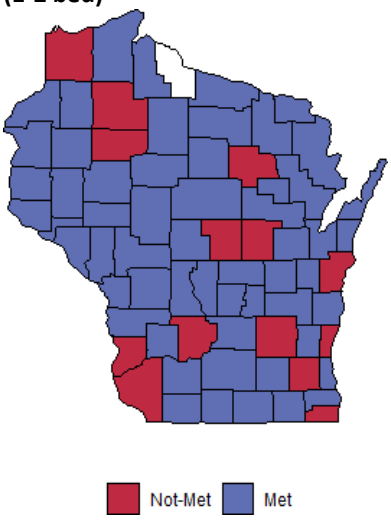
1 (Tie) Supported Employment - Small Group



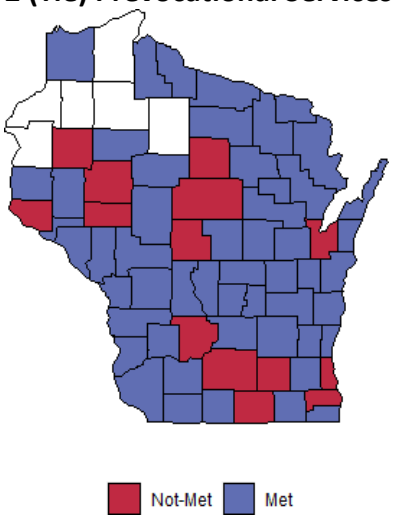
2 (Tie) Adult Day Care



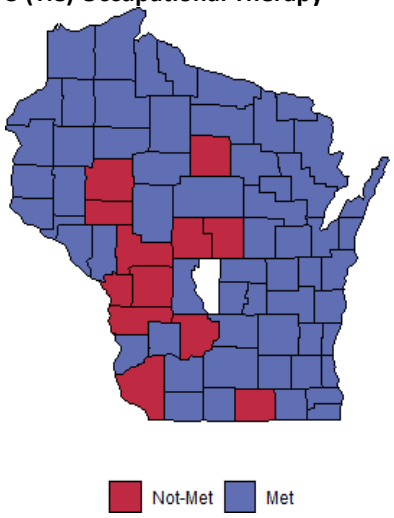
2 (Tie) Adult Residential Care (1-2 bed)



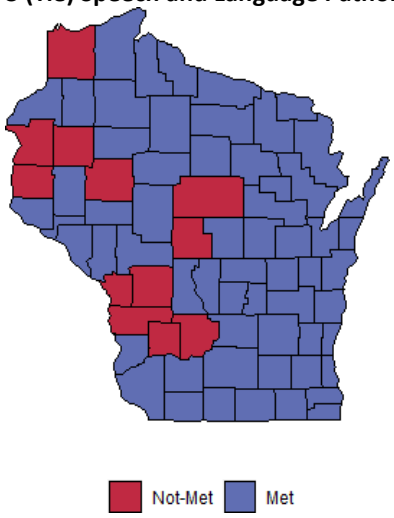
2 (Tie) Prevocational Services



3 (Tie) Occupational Therapy

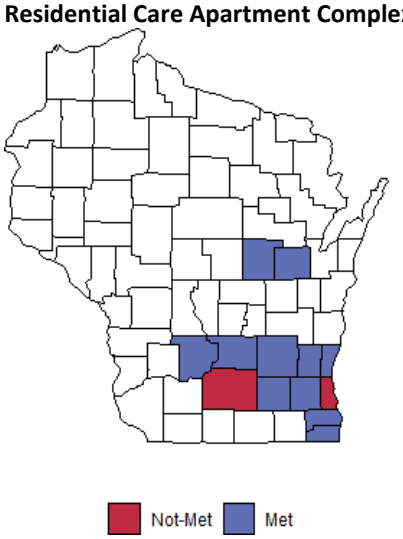


3 (Tie) Speech and Language Pathology Services

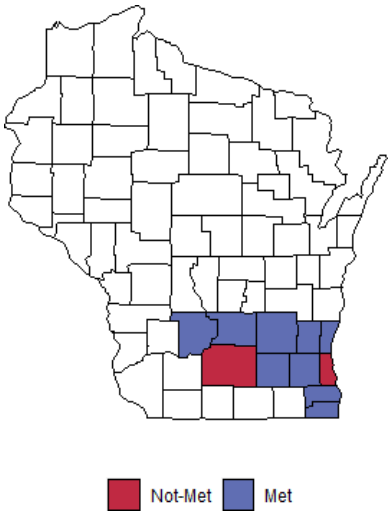


Family Care Partnership

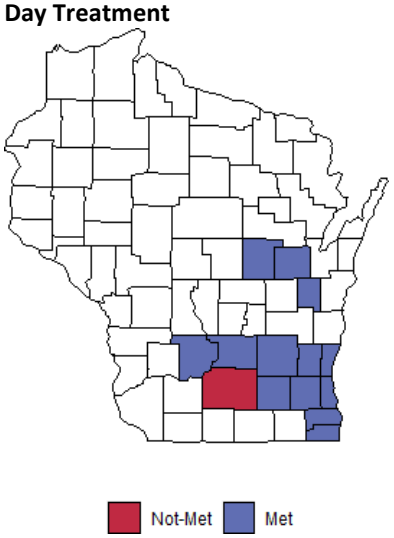
1 (Tie) Adult Residential Care - Residential Care Apartment Complex



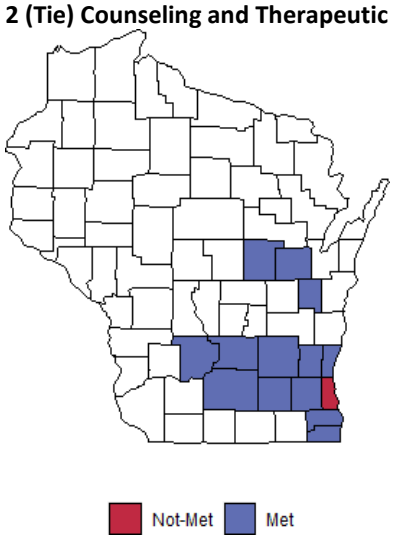
1 (Tie) Transportation (Excluding Ambulance)



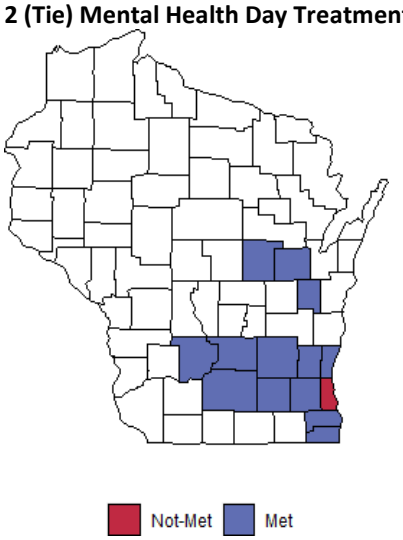
2 (Tie) Alcohol and Other Drug Abuse Day Treatment



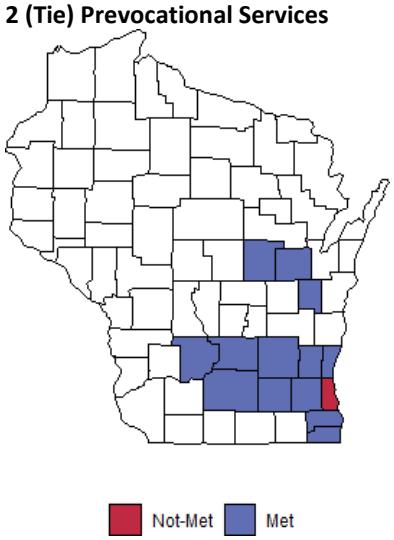
2 (Tie) Counseling and Therapeutic Resources



2 (Tie) Mental Health Day Treatment

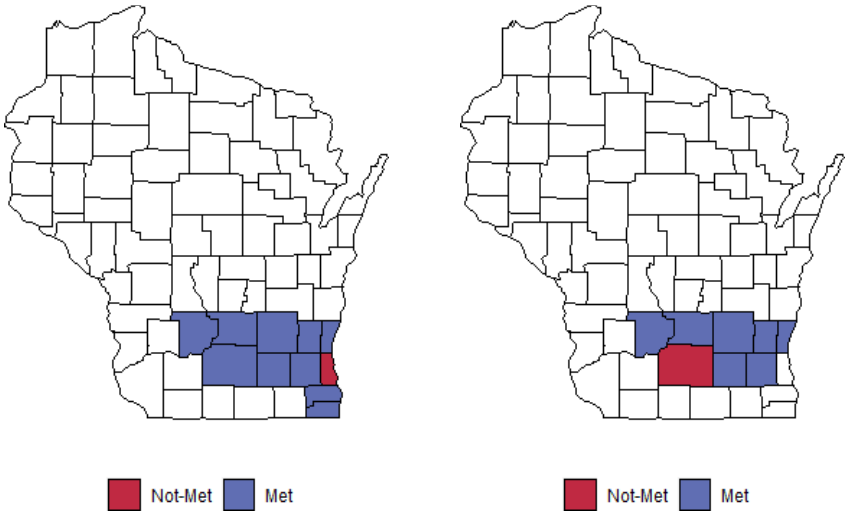


2 (Tie) Prevocational Services



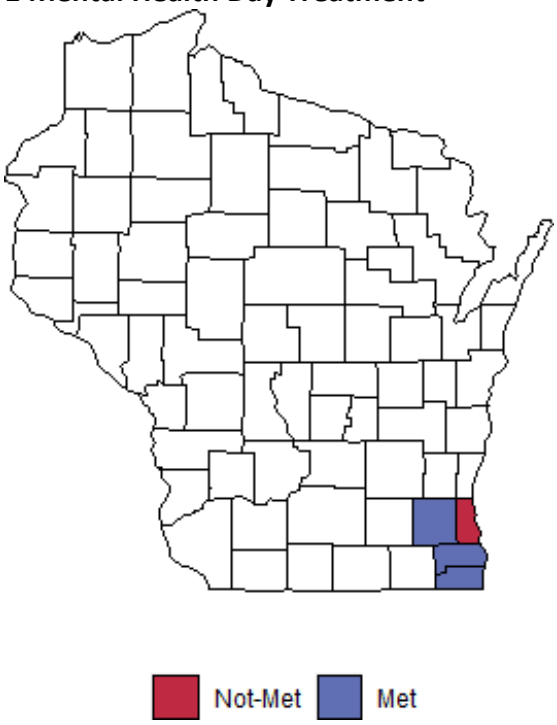
2 (Tie) Supported Employment - Small Group

2 (Tie) Transportation (Specialized) – Other



PACE

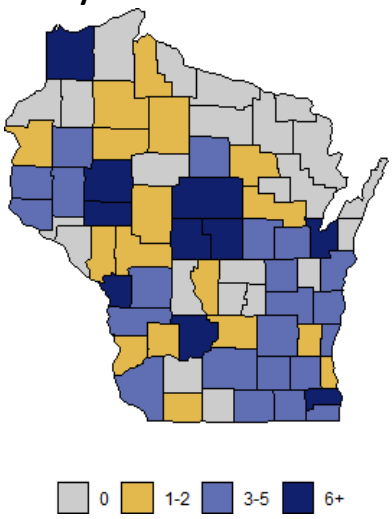
1 Mental Health Day Treatment



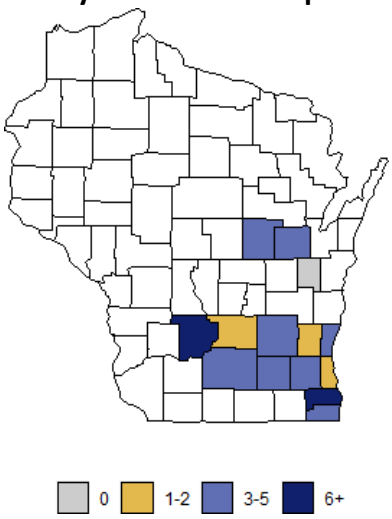
*** All other service types met the target in all counties served**

Number of Service Types Not Meeting Target by County

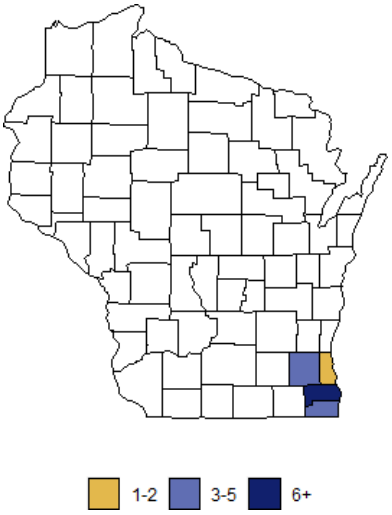
Family Care



Family Care Partnership



PACE



Progress on Previous EQRO Plan Level Recommendations

The protocol was implemented in FY 23-24; therefore, there is no progress to assess.

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 Waiver, which allows 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. Four indicators were added to the review in Fiscal Year 2022-2023 (FY 22-24), making the overall results not comparable to results from prior years. Additionally, in FY 23-24, changes were made to scoring criteria for several indicators, making results from some scoring elements not comparable to results from prior years. Results from prior years will be included for the overall results and all indicators as a reference and narrative explanation will be included with details on changes or lack of comparability.

When year-to-year results are comparable, a Pearson's chi-squared test, a statistical technique used to determine whether there is a statistically significant difference between the year-to-year results, was used. When statistical change is identified, the change is likely a result of actions taken by the MCO, or other contributing factor, and unlikely to be attributed to normal variation or chance. When statistical change is not identified, any change in rates is likely due to normal variation of chance. This type of analysis identifies strategies that are effective in creating improvements in care management practices.

Strengths and opportunities for improvement are identified for each review indicator. Strengths are defined as areas of practice that scored at or above 90 percent. Opportunities for improvement are areas of practice scoring below 90 percent.

The following MCOs and programs were included in the CMR:

Managed Care Organization	Program(s)
Community Care, Inc. (CCI)	FC; FCP; PACE
Inclusa, Inc. (Inclusa)	FC

Managed Care Organization	Program(s)
Lakeland Care, Inc. (LCI)	FC
My Choice Wisconsin, Inc. (MCW)	FC; FCP

*i*Care did not undergo a care management review in FY 23-24 due to the acquisition of Inclusa, which changed the review schedule for *i*Care. Historically, the CMR for *i*Care was conducted in March. With the acquisition of Inclusa, the organizations will be evaluated as one entity in July and August for both reviews, starting in FY 24-25. This change would have made a CMR in March and again in July for *i*Care, which is less than six months apart and would have overlapping review periods and inadequate time for improvement efforts to be implemented. The decision was made to forgo the CMR in FY 23-24, which makes the overall sample size for FCP smaller compared to prior years.

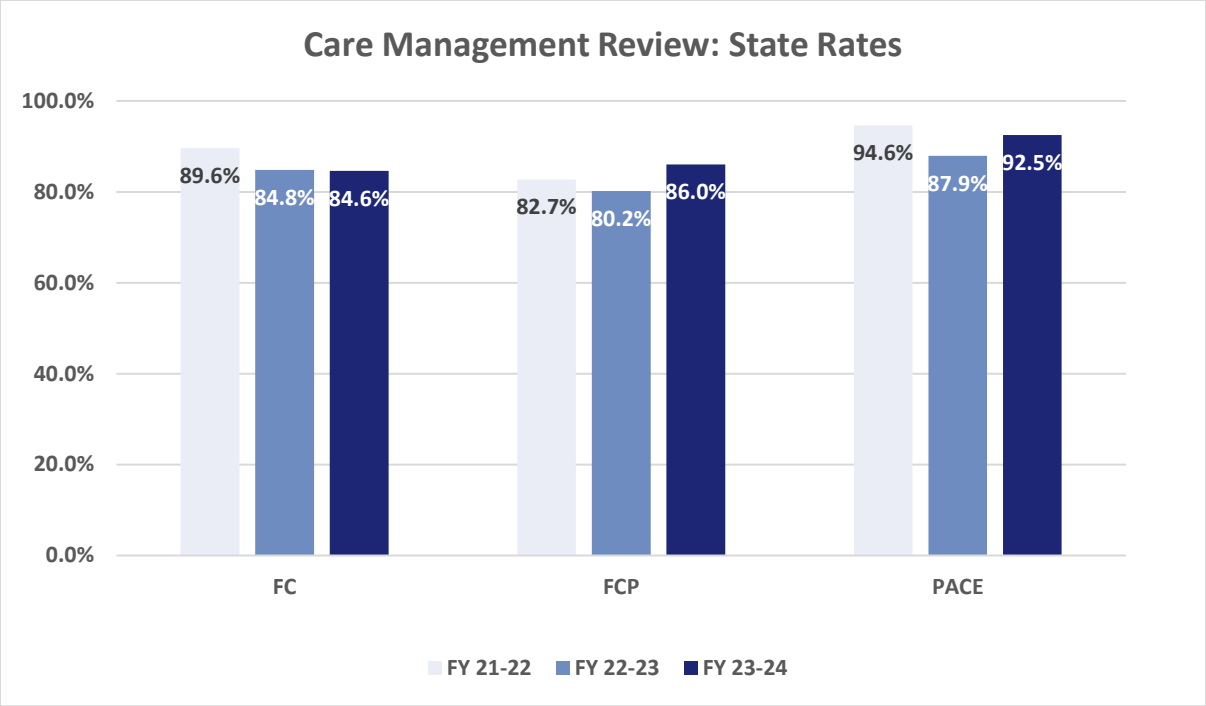
The table below identifies the number of records reviewed for each program in the prior fiscal years.

Record Volume by Program			
Program	**FY 21-22**	**FY 22-23**	**FY 23-24**
FC	1,051	1,061	1,057
FCP	652	655	419
PACE	182	179	175
Total	**1,885**	**1,895**	**1,651**

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 21-22, FY 22-23, and FY 23-24 for all review indicators. Year-to-year results are not comparable due to changes in review criteria.



The overall results for each MCO and program are found in Appendix 6 of this report. CCI is the only MCO operating the PACE program; therefore, there are no MCO level comparisons for this program.

Results were further analyzed based on Geographic Service Regions (GSRs) for each program. The links to the GSR maps below identify which MCOs serve in each GSR:

Family Care Geographic Service Region Map (wisconsin.gov)

PACE/Partnership Geographic Service Region Map (wisconsin.gov)

DHS is in the process of consolidating GSRs. The reconfiguration began in 2023 with the consolidation of GSR 7 into GSR 1. The complete timeline for GSR reconfiguration can be found at the link below:

Family Care and IRIS Geographic Service Regions (GSR) Reconfiguration Timeline (wisconsin.gov)

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 recommended 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 FY 21-22, FY 22-23, and FY 23-24 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

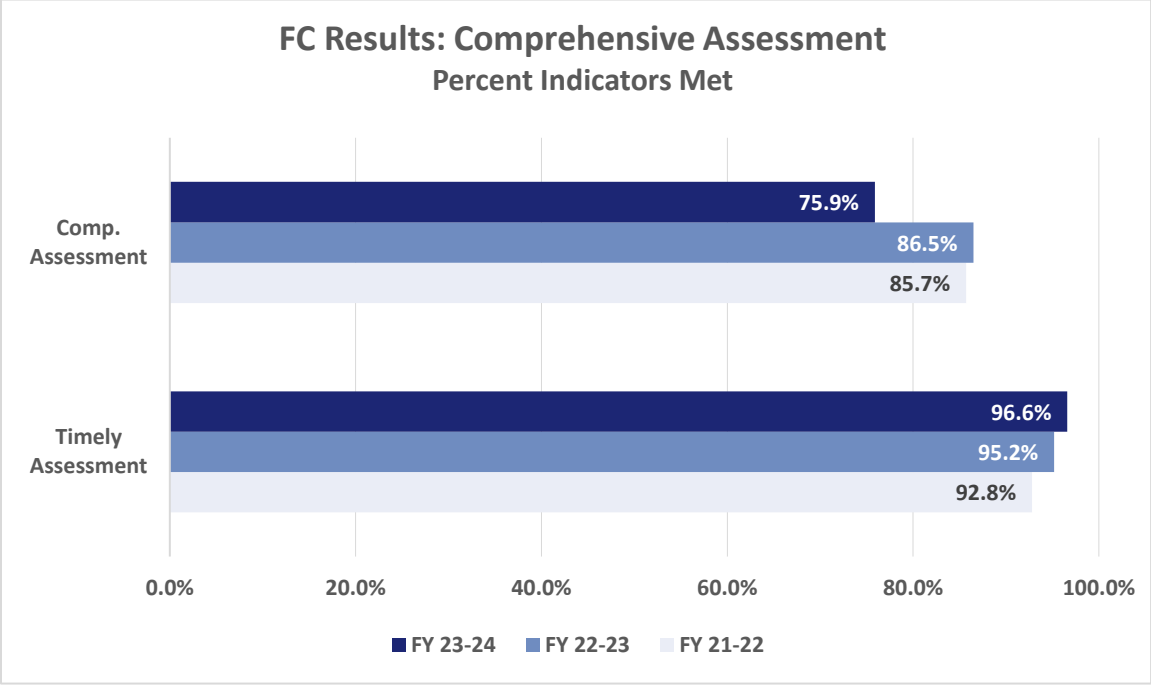
The indicator *Comprehensive Assessment (1A)* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. Of all applicable assessment elements reviewed, 98.7 percent were found to be assessed. Results for the indicator on a per record basis indicated a need for improvement. Results from prior reviews are not comparable, as additional assessment criteria related to the member's understanding of rights and understanding of abuse, neglect, and exploitation was evaluated for comprehensiveness in FY 23-24.

Assessments not found comprehensive most often did not include an assessment of the member's understanding of abuse, neglect, and exploitation, as well as an assessment of the

member's understanding of individual rights. These were new assessment requirements evaluated in FY 23-24. FC GSRs 1, 2, 3, 4, 5, 8, 11, 12, and 14 demonstrated the most need for improvement, while FC GSR 9 demonstrated the strongest practices for comprehensive assessments.

The indicator *Timely Assessment (1B)* evaluates assessments conducted by both members of the IDT in accordance with the DHS-MCO contract requirement of every six months. Results for the indicator were similar to the prior review and demonstrated strengths. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. All FC GSRs demonstrated strong practices, with all scoring above 90 percent.

Results for Comprehensive Assessment for MCOs Operating FC:



The table below displays the results for this focus area by each FC GSR in FY 23-24.

Comprehensive Assessment			
FC GSRs	**Records**	**Indicator Identification**	
MCOs Serving Each GSR	*Number Reviewed*	*1A*	*1B*
GSR 1: Inclusa, MCW	85	42.4%	94.1%
GSR 2: Inclusa, MCW	85	44.7%	92.9%
GSR 3: Inclusa, MCW	37	70.3%	97.3%

Comprehensive Assessment			
FC GSRs	**Records**	**Indicator Identification**	
MCOs Serving Each GSR	*Number Reviewed*	*1A*	*1B*
GSR 4: Inclusa, LCI	91	64.8%	100.0%
GSR 5: Inclusa, MCW	57	75.4%	98.2%
GSR 6: CCI, Inclusa, MCW	99	88.9%	98.0%
GSR 8: CCI, MCW	181	83.4%	92.8%
GSR 9: CCI, Inclusa, LCI	96	91.7%	100.0%
GSR 10: CCI, Inclusa, LCI	72	87.5%	97.2%
GSR 11: CCI, Inclusa, MCW	61	75.4%	96.7%
GSR 12: CCI, MCW	46	80.4%	93.5%
GSR 13: Inclusa, LCI	133	88.0%	99.2%
GSR 14: Inclusa, MCW	14	71.4%	100.0%
Totals	**1,057**	**75.9%**	**96.6%**

Please see Appendix 6 for a MCO comparison of the results of this focus area for each MCO operating the FC program in FY 23-24.

FCP

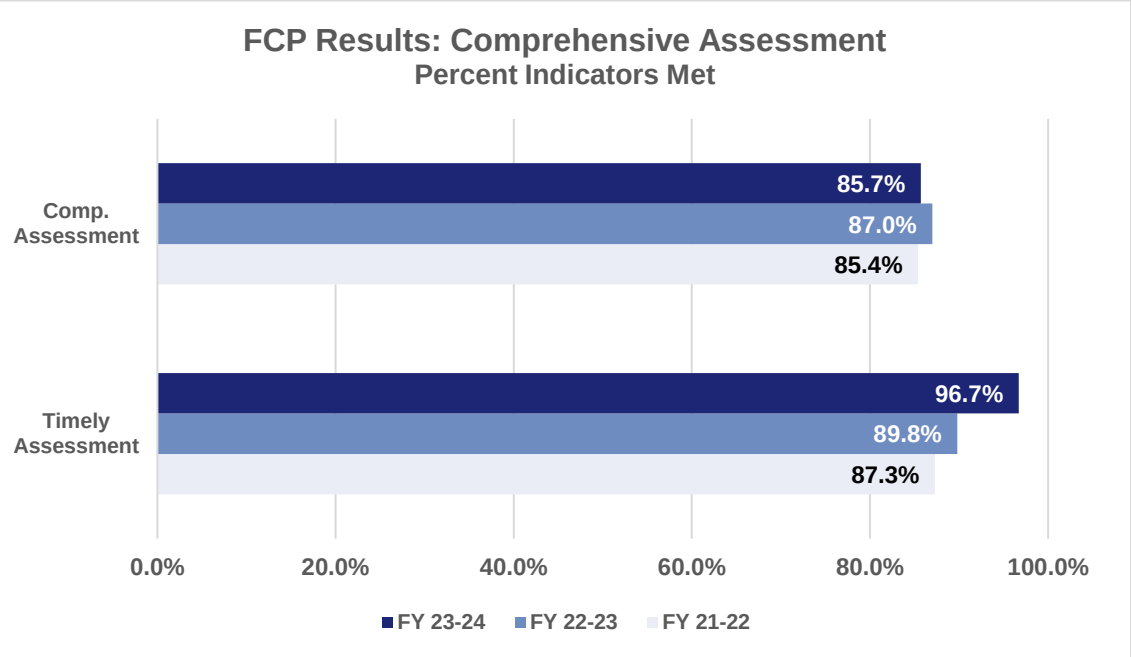
The indicator *Comprehensive Assessment (1A)* ensures the MCO evaluates member needs based on the DHS-MCO contract requirements. Of all applicable assessment elements reviewed, 99.4 percent were found to be assessed. Results for the indicator on a per record basis indicated a need for improvement. Results from prior reviews are not comparable, as additional assessment criteria related to the member's understanding of rights and understanding of abuse, neglect, and exploitation was evaluated for comprehensiveness in FY 23-24.

Assessments not found comprehensive most often did not include a detailed description of behaviors for members taking behavior modifying medications. FCP GSRs 8, 10, 12, and 13 demonstrated the most need for improvement, while FCP GSRs 3, 5, 6, 9, and 11 evidenced the strongest practices.

The indicator *Timely Assessment (1B)* evaluates assessments conducted by both members of the IDT in accordance with the DHS-MCO contract requirement of every six months. Results for the indicator improved from the prior review and demonstrated strong practices. Analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs,

and is unlikely to be the result of normal variation or chance. All FCP GSRs demonstrated strong practices, with all scoring above 90 percent.

Results for Comprehensive Assessment for MCOs Operating FCP:



The table below displays the results for this focus area by each FCP GSR in FY 23-24.

Comprehensive Assessment			
FCP GSRs	**Records**	**Indicator Identification**	
MCOs Serving Each GSR	*Number Reviewed*	*1A*	*1B*
GSR 3: MCW	2	100.0%	100.0%
GSR 5: MCW	31	90.3%	96.8%
GSR 6: CCI, MCW	42	97.6%	100.0%
GSR 8: CCI, *i*Care*	85	68.2%	95.3%
GSR 9: MCW	2	100.0%	100.0%
GSR 10: CCI	33	87.9%	100.0%
GSR 11: CCI, *i*Care*	44	90.9%	100.0%
GSR 12: *i*Care*, MCW	173	89.0%	94.8%
GSR 13: MCW	5	60.0%	100.0%
Totals**	**419**	**85.7%**	**96.7%**

**Note: iCare was not evaluated in FY 23-24.*

***Note: Two FCP members resided outside of the FCP GSRs and are included in the total, but not added to a specific GSR above.*

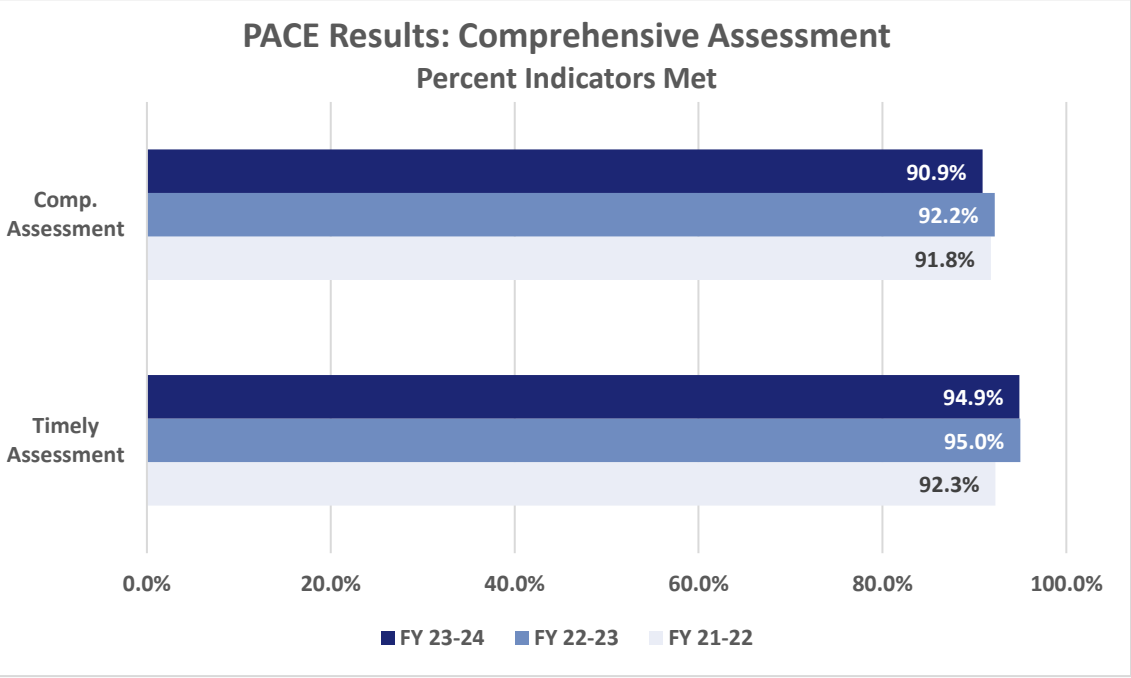
Please see Appendix 6 for a MCO comparison of the results of this focus area for each MCO operating the FCP program in FY 23-24.

PACE

The indicator *Comprehensive Assessment (1A)* 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 on a per record basis indicated strengths. Results from prior reviews are not comparable, as additional assessment criteria related to the member's understanding of rights and understanding of abuse, neglect, and exploitation was evaluated for comprehensiveness in FY 23-24. All PACE GSRs demonstrated strong practices, with all scoring above 90 percent.

The indicator *Timely Assessment (1B)* evaluates assessments conducted by both members of the IDT in accordance with the DHS-MCO contract requirement of every six months. Results for the indicator were similar to the prior review and demonstrated strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. All PACE GSRs demonstrated strong practices, with all scoring above 90 percent.

Results for Comprehensive Assessment for MCOs Operating PACE:



The table below displays the results for this focus area by each PACE GSR in FY 23-24.

Comprehensive Assessment			
PACE GSRs	**Records**	**Indicator Identification**	
MCOs Serving Each GSR	*Number Reviewed*	*1A*	*1B*
GSR 6: CCI	28	92.9%	96.4%
GSR 8: CCI	121	90.1%	95.9%
GSR 11: CCI	25	92.0%	92.0%
Totals*	**175**	**90.9%**	**94.9%**

**Note: One PACE member resided outside of the PACE GSRs and is included in the total, but not added to a specific GSR above.*

CCI is the only MCO operating the PACE program; therefore, there are no MCO level comparisons.

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 (2A)* ensures member MCPs include all assessed needs. Of all MCP elements reviewed, 95.7 percent were found to be included on the plan. Results for the indicator on a per record basis declined from the prior review and indicated a need for improvement. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance.

MCPs that were not comprehensive most often did not include a service or support for a member's assessed toileting or bathing needs. Services or supports for these needs include caregivers, durable medical equipment (DME), and disposable medical supplies (DMS). All FC GSRs demonstrated a need for improvement.

The indicator *Timely MCP (2B)* evaluates MCPs being reviewed and signed in accordance with the DHS-MCO contract requirement of every six months. Results for the indicator on a per record basis were similar to the prior review and indicated opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

The majority of records unmet for this indicator did not evidence a signature on the prior MCP, which makes the current MCP not timely. Other records reflected MCPs were reviewed, but not signed within the required timeframe. All FC GSRs demonstrated a need for improvement, with the exception of FC GSRs 13 and 14, which demonstrated strong practices.

MCPs were found to be signed at least once annually in 96.1 percent of all records (Indicator 2C). All FC GSRs demonstrated strong practices for this requirement, with all scoring above 90 percent.

The indicator *Change in Condition (2D)* 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 on a per record basis were similar to the prior review and demonstrated strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. FC GSRs 3, 4, 5, 8, 9, and 11 demonstrated strong practices related to these requirements. FC GSRs 1, 2, 6, 10, 12, 13, and 14 indicated an opportunity for improvement in related practices. Most changes in condition not properly assessed were related to a hospitalization or emergency room visit.

The indicator *Service Authorizations (2E)* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests, and issuing *Notices of Adverse Benefit Determination* when applicable. Results for the indicator on a per record basis were similar to the prior review and demonstrated strengths. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Overall, service authorizations were handled appropriately and all but FC GSRs2, 4, and 12, demonstrated strong practices.

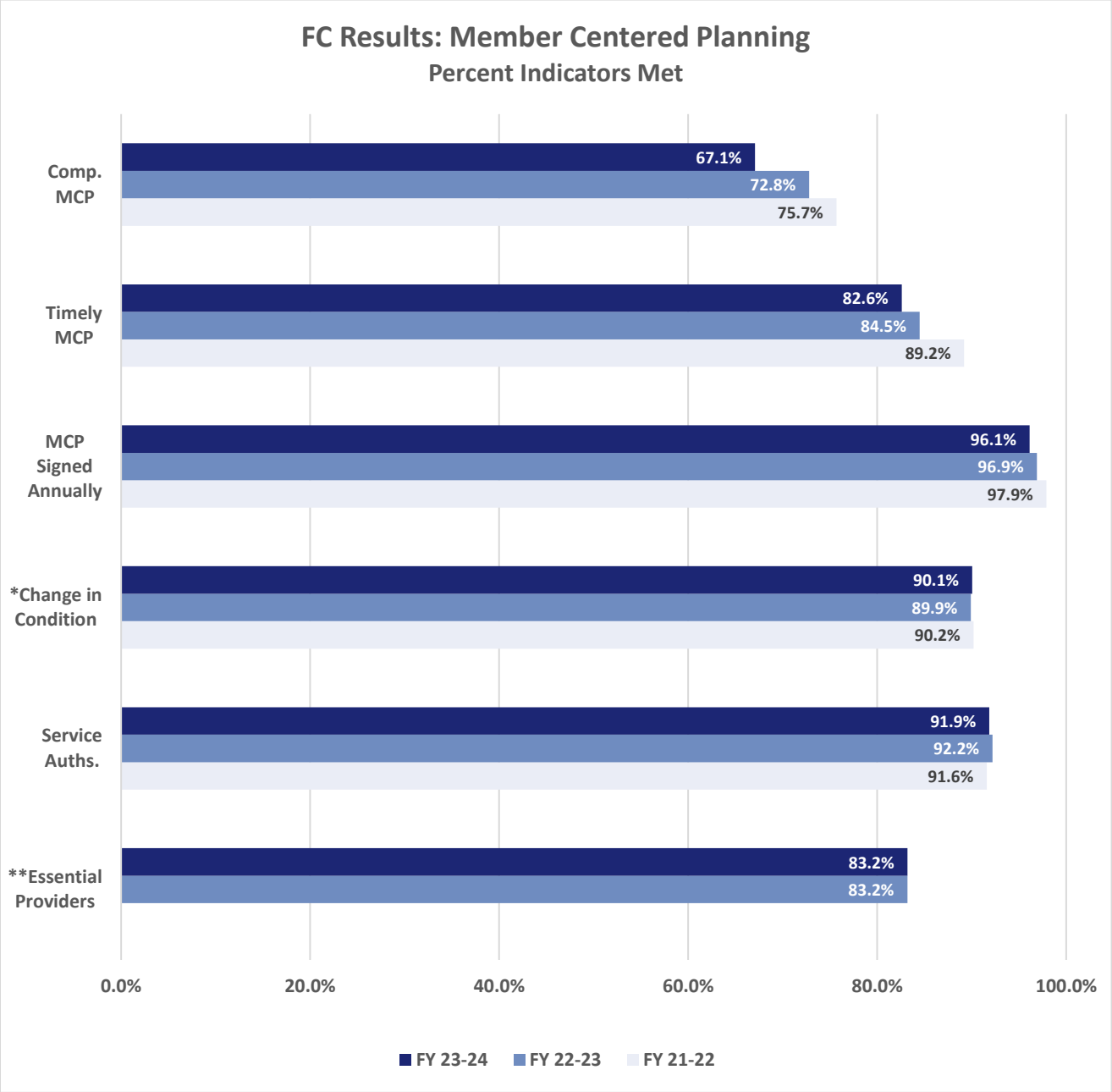
In multiple cases, *Notices of Adverse Benefit Determination* were indicated but not issued, often related to the IDT not making a decision on a member's request. In all FC records reviewed, 284

Notices of Adverse Benefit Determination were indicated, with 166 being issued timely, for an issuance rate of 58.5 percent.

The indicator *Essential Providers (2F)* 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. Results for the indicator on a per record basis were similar to the prior review and indicated opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

Records found not met for this indicator most often did not include a signature for supportive home care (SHC) providers. FC GSRs 1, 2, 3, 4, 6, 8, 11, 12, 13, and 14 indicated the most need for improvement, while FC GSRs 5, 9, and 10 demonstrated the strongest practices.

Results for Member Centered Planning for MCOs Operating FC:



*Note: The review indicator *Change in Condition* applied to 387 of 1,051 records in FY 21-22, 375 of 1,061 records in FY 22-23, and 392 of 1,057 records in FY 23-24.
**Note: The review indicator *Essential Providers* applied to 817 of 1,061 records in FY 22-23 and 840 of 1,057 records in FY 23-24. This requirement was newly evaluated in FY 22-23 and there are no results for FY 21-22.

The table on the next page displays the results for this focus area by each FC GSR in FY 23-24.

Member Centered Planning							
FC GSRs	**Records**	**Indicator Identification**					
MCOs Serving Each GSR	*Number Reviewed*	*2A*	*2B*	*2C*	*2D*	*2E*	*2F*
GSR 1: Inclusa, MCW	85	61.2%	78.8%	96.5%	86.2%	90.6%	78.3%
GSR 2: Inclusa, MCW	85	57.6%	84.7%	98.8%	81.5%	88.2%	78.9%
GSR 3: Inclusa, MCW	37	59.5%	89.2%	100.0%	100.0%	91.9%	76.9%
GSR 4: Inclusa, LCI	91	52.7%	75.8%	94.5%	96.9%	84.6%	84.5%
GSR 5: Inclusa, MCW	57	86.0%	89.5%	100.0%	100.0%	91.2%	91.3%
GSR 6: CCI, Inclusa, MCW	99	76.8%	79.8%	94.9%	89.2%	94.9%	82.9%
GSR 8: CCI, MCW	181	67.4%	80.1%	95.0%	94.7%	92.3%	75.3%
GSR 9: CCI, Inclusa, LCI	96	72.9%	87.5%	93.8%	90.0%	96.9%	91.4%
GSR 10: CCI, Inclusa, LCI	72	66.7%	83.3%	97.2%	78.3%	91.7%	91.5%
GSR 11: CCI, Inclusa, MCW	61	60.7%	78.7%	93.4%	93.8%	91.8%	74.5%
GSR 12: CCI, MCW	46	76.1%	63.0%	91.3%	85.0%	89.1%	88.1%
GSR 13: Inclusa, LCI	133	69.2%	92.5%	98.5%	88.0%	94.7%	88.1%
GSR 14: Inclusa, MCW	14	64.3%	92.9%	100.0%	71.4%	92.9%	81.8%
Totals	**1,057**	**67.1%**	**82.6%**	**96.1%**	**90.1%**	**91.9%**	**83.2%**

Please see Appendix 6 for a MCO comparison of the results of this focus area for each MCO operating the FC program in FY 23-24.

FCP

The indicator *Comprehensive MCP (2A)* ensures member MCPs include all assessed needs. Of all MCP elements reviewed, 98.2 percent were found to be included on the plan. Results for the indicator on a per record basis 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.

MCPs that were not comprehensive most often did not include a service or support for a member's assessed mobility or toileting needs. Services and supports for mobility were most often a caregiver. Services and supports for toileting were most often DMS for incontinence needs. FCP GSRs 8, 10, 11, 12, and 13 indicated the most need for improvement, while FCP GSRs 3, 5, 6, and 9 demonstrated strong practices.

The indicator *Timely MCP (2B)* evaluates MCPs being reviewed and signed in accordance with the DHS-MCO contract requirement of every six months. Results for the indicator on a per

record basis improved from the prior review, but still indicated opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance.

The majority of records unmet for this indicator reflected MCPs were reviewed, but not signed within the required timeframe. Other records did not evidence a signature on the prior MCP, which makes the current MCP not timely. FCP GSRs 5, 6, 8, 11, 12, and 13 indicated the most need for improvement, while FCP GSRs 3, 9, and 10 demonstrated strong practices.

MCPs were found to be signed at least once annually in 94.7 percent of all records (Indicator 2C). All FCP GSRs, with the exception of GSR 8 and 13, demonstrated strong practices with these requirements.

The indicator *Change in Condition (2D)* 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 on a per record basis were similar to the prior review and demonstrated strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance.

Most FCP GSRs demonstrated strong practices with these requirements; however, FCP GSRs 5 and 8 indicated a need for improvement. Most changes in condition not properly assessed were related to a hospitalization or emergency room visit.

The indicator *Service Authorizations (2E)* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests, and issuing *Notices of Adverse Benefit Determination* when applicable. Results for the indicator on a per record basis were similar to the prior review and demonstrated strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. Overall, service authorizations were handled appropriately in all but two FCP GSRs, GSR 5 and 13, demonstrated strong practices.

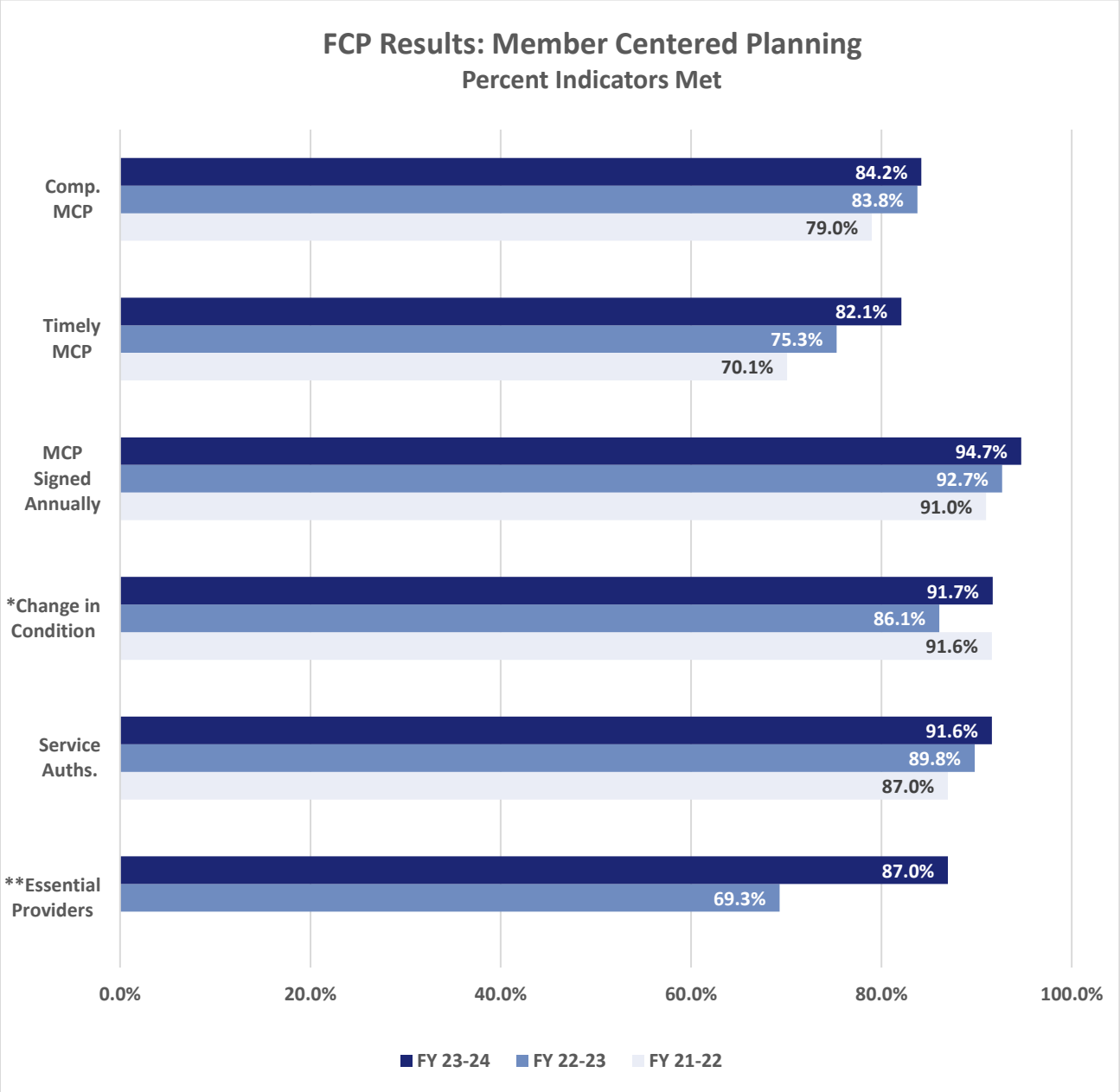
In multiple cases, *Notices of Adverse Benefit Determination* were indicated but not issued, often related to the IDT not making a decision on a member's request. In all FCP records reviewed, 97 *Notices of Adverse Benefit Determination* were indicated, with 51 being issued timely, for an issuance rate of 52.6 percent.

The indicator *Essential Providers (2F)* 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. Results for the indicator on a per record basis improved from the prior review, but still indicated opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely attributable to actions of the MCOs, and is unlikely to be the result of normal variation or chance.

Records found not met for this indicator most often did not include a signature for community based residential facilities (CBRF) and SHC providers. FCP GSRs 5, 8, 12, and 13 indicated the most need for improvement, while FCP GSRs 3, 6, 9, 10, and 11 demonstrated strong practices.

Results for Member Centered Planning for MCOs Operating FCP:



*Note: The review indicator *Change in Condition* applied to 320 of 652 records in FY 21-22, 238 of 655 records in FY 22-23, and 193 of 419 records in FY 23-24.
**Note: The review indicator *Essential Providers* applied to 492 of 655 records in FY 22-23 and 324 of 419 records in FY 23-24. This requirement was newly evaluated in FY 22-23 and there are no results for FY 21-22.

The table on the next page displays the results for this focus area by each FCP GSR in FY 23-24.

Member Centered Planning							
FCP GSRs	**Records**	**Indicator Identification**					
MCOs Serving Each GSR	*Number Reviewed*	*2A*	*2B*	*2C*	*2D*	*2E*	*2F*
GSR 3: MCW	2	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
GSR 5: MCW	31	96.8%	83.9%	93.5%	88.2%	83.9%	87.5%
GSR 6: CCI, MCW	42	92.9%	88.1%	97.6%	95.0%	92.9%	93.3%
GSR 8: CCI, *i*Care*	85	64.7%	64.7%	89.4%	83.3%	94.1%	85.7%
GSR 9: MCW	2	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
GSR 10: CCI	33	87.9%	93.9%	100.0%	93.3%	100.0%	92.3%
GSR 11: CCI, *i*Care*	44	84.1%	88.6%	100.0%	100.0%	90.9%	96.8%
GSR 12: *i*Care*, MCW	173	89.0%	84.4%	94.8%	92.1%	90.2%	84.6%
GSR 13: MCW	5	60.0%	80.0%	80.0%	100.0%	80.0%	0.0%
Totals**	**419**	**84.2%**	**82.1%**	**94.7%**	**91.7%**	**91.6%**	**87.0%**

**Note: iCare was not evaluated in FY 23-24.*
***Note: Two FCP members resided outside of the FCP GSRs and are included in the total, but not added to a specific GSR above.*

Please see Appendix 6 for an MCO comparison of the results of this focus area for each MCO operating the FCP program in FY 23-24.

PACE

The indicator *Comprehensive MCP (2A)* ensures member MCPs include all assessed needs. Of all MCP elements reviewed, 99.5 percent were found to be included on the plan. Results for the indicator on a per record basis were similar to the prior review and demonstrated strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. All PACE GSRs demonstrated strong practices, with all scoring above 90 percent.

The indicator *Timely MCP (2B)* evaluates MCPs being reviewed and signed in accordance with the DHS-MCO contract requirement of every six months. Results for the indicator on a per record basis were similar to the prior review and indicated opportunities for improvement. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. In the majority of records found unmet, MCPs were reviewed, but not signed within six months. Additionally, several records did not have evidence of a signature on the prior MCP. Two PACE GSRs, GSR 6 and 11, indicated the most need for improvement, while PACE GSR 8 demonstrated strengths.

MCPs were found to be signed at least once annually in 99.4 percent of all records (Indicator 2C). All PACE GSRs demonstrated strong practices, with all scoring above 90 percent.

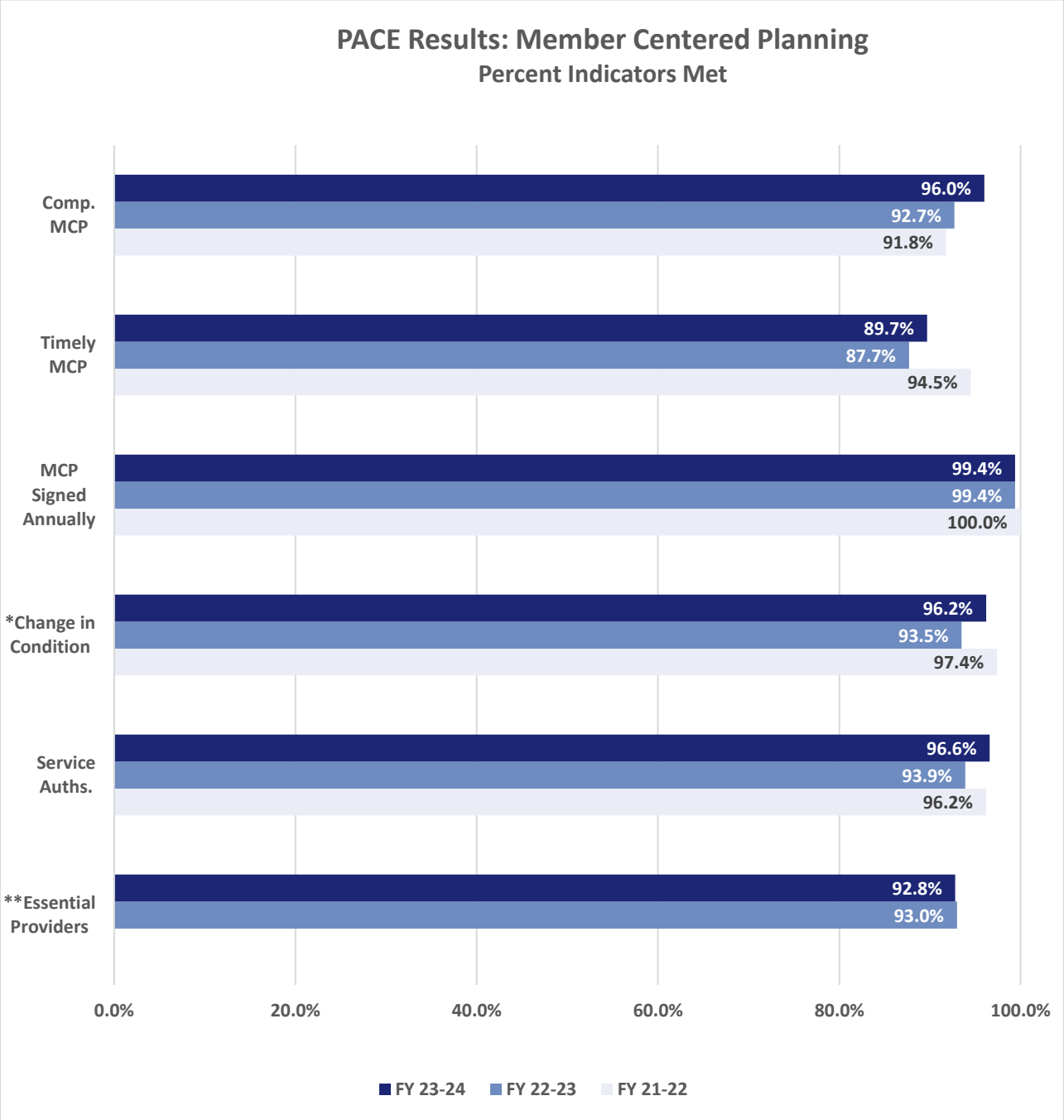
The indicator *Change in Condition (2D)* evaluates the IDTs assessing the member when changes occur and updating the MCP when applicable, which includes the exploration or education on risk interventions. Results for the indicator on a per record basis were similar to the prior review and demonstrated strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. All PACE GSRs demonstrated strong practices, with all scoring above 90 percent.

The indicator *Service Authorizations (2E)* evaluates the IDTs handling of service authorizations, including appropriately responding to member requests, and issuing *Notices of Adverse Benefit Determination* when applicable. Results for the indicator on a per member basis were similar to the prior review and demonstrated strengths. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. All PACE GSRs demonstrated strong practices, with all scoring above 90 percent.

Overall, service authorizations were handled appropriately. In several cases, *Notices of Adverse Benefit Determination* were indicated but not issued, most often related to the IDT not making a timely decision on a member's request. In all PACE records reviewed, 23 *Notices of Adverse Benefit Determination* were indicated, with 17 being issued timely, for an issuance rate of 73.9 percent.

The indicator *Essential Providers (2F)* 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. Results for the indicator on a per record basis 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. All PACE GSRs demonstrated strong practices related to these requirements.

Results for Member Centered Planning for MCOs Operating PACE:



*Note: The review indicator *Change in Condition* applied to 77 of 182 records in FY 21-22, 92 of 179 records in FY 22-23, and 79 of 175 records in FY 23-24.
**Note: The review indicator *Essential Providers* applied to 142 of 179 records in FY 22-23, and 138 of 175 records in FY 23-24. This requirement was newly evaluated in FY 22-23 and there are no results for FY 21-22.

The table below displays the results for this focus area by each PACE GSR in FY 23-24.

Member Centered Planning							
PACE GSRs	**Records**	**Indicator Identification**					
MCOs Serving Each GSR	*Number Reviewed*	*2A*	*2B*	*2C*	*2D*	*2E*	*2F*
GSR 6: CCI	28	92.9%	89.3%	100.0%	100.0%	100.0%	95.2%
GSR 8: CCI	121	96.7%	90.1%	99.2%	94.3%	95.9%	92.6%
GSR 11: CCI	25	96.0%	88.0%	100.0%	100.0%	96.0%	91.3%
Totals*	**175**	**96.0%**	**89.7%**	**99.4%**	**96.2%**	**96.6%**	**92.8%**

**Note: One PACE member resided outside of the PACE GSRs and is included in the total, but not added to a specific GSR above.*

CCI is the only MCO operating the PACE program; therefore, there are no MCO level comparisons.

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 *Timely Coordination (3A)* indicator evaluates plans put in place by the IDT to ensure member needs and supports are coordinated effectively and in a timely manner. Results for the indicator on a per record basis indicated strong practices. Results from prior reviews are not comparable, as the threshold to determine compliance changed. In prior reviews coordination was expected within 30 calendar days. The threshold changed to the end of the month following identification of the need in FY 23-24. All FC GSRs demonstrated strong practices, with all scoring above 90 percent.

The indicator *Timely Follow-Up (3B)* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Results for the indicator on a per record basis indicated a need for improvement. Results from prior reviews are not comparable,

as the threshold to determine compliance changed. In prior reviews follow-up was expected within 30 calendar days. The threshold changed to the end of the month following identification of the need in FY 23-24.

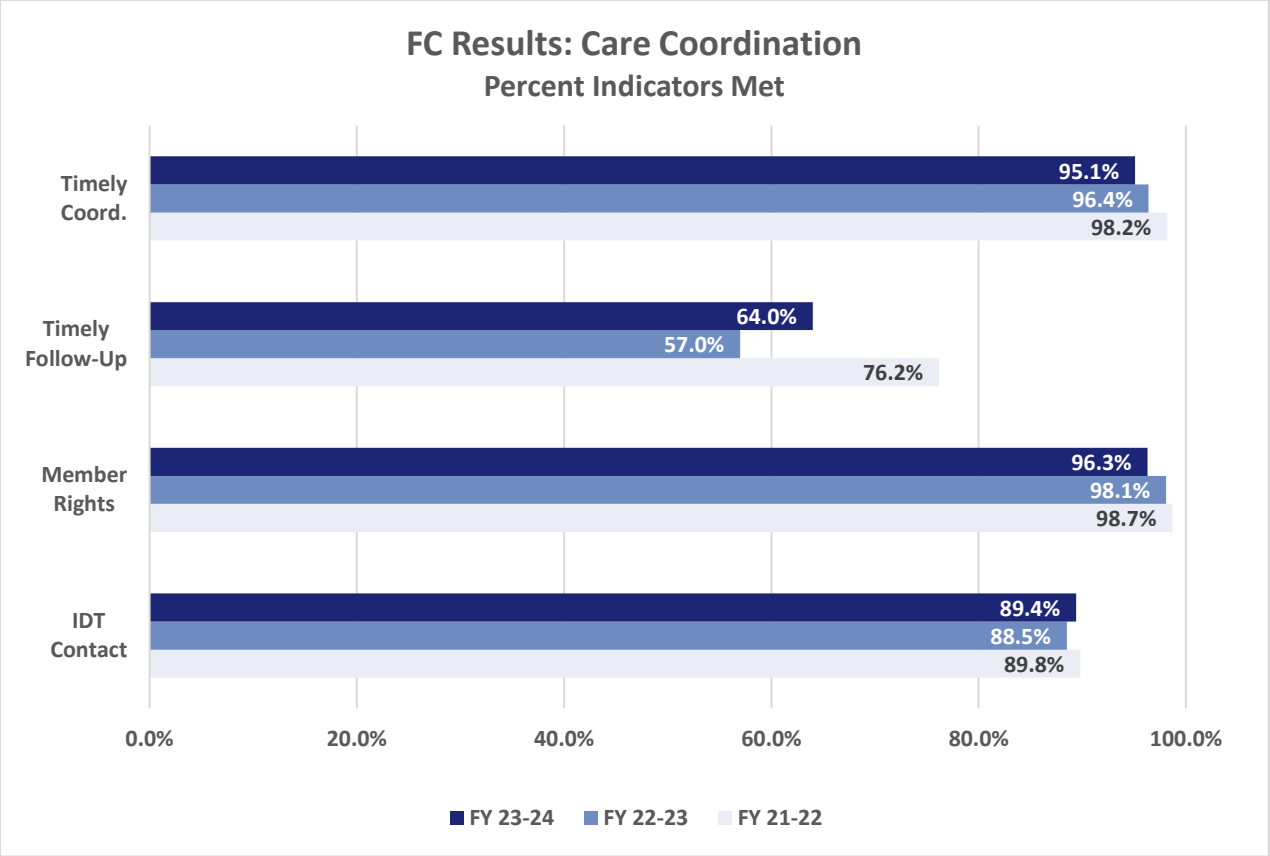
Records found not met for this indicator most often did not include evidence of follow-up for service related needs. These are needs related to member's services, such as SHC, self-directed supports, and other provider-type services. Follow-up to member's medical appointments was another common reason for records to be unmet for this indicator. All FC GSRs indicated the need for improvement.

The indicator *Member Rights (3C)* 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 on a per record basis declined from the prior review, but still demonstrated strong practices. Analysis indicated the year-to-year difference in the rates is unlikely to be the result of normal variation or chance. All FC GSRs demonstrated strong practices, with all scoring above 90 percent.

The evaluation of IDT contact requirements under the indicator *IDT Contact (3D)*, included monthly collateral contacts, face-to-face 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 on a per record basis indicated a need for improvement. Results from prior reviews are not comparable, as new requirements for members residing in one and two bed adult family homes was included in the evaluation in FY 23-24.

Records not meeting requirements most often did not include evidence of a monthly telephone contact with the member, legal decision maker, or other appropriate person. Evidence of an in-person contact with the member every three months was another common reason for records to be not met. FC GSRs 1, 2, 5, 8, 11, 12, and 14 indicated the greatest need for improvement, while FC GSRs 3, 4, 6, 9, 10, and 13 demonstrated strong practices.

Results for Care Coordination for MCOs Operating FC:



The table below displays the results for this focus area by each FC GSR in FY 23-24.

Care Coordination					
FC GSRs	**Records**	**Indicator Identification**			
MCOs Serving Each GSR	*Number Reviewed*	*3A*	*3B*	*3C*	*3D*
GSR 1: Inclusa, MCW	85	95.3%	61.2%	97.6%	80.0%
GSR 2: Inclusa, MCW	85	94.1%	57.6%	98.8%	84.7%
GSR 3: Inclusa, MCW	37	94.6%	56.8%	94.6%	100.0%
GSR 4: Inclusa, LCI	91	94.5%	68.1%	96.7%	91.2%
GSR 5: Inclusa, MCW	57	96.5%	56.1%	100.0%	82.5%
GSR 6: CCI, Inclusa, MCW	99	97.0%	70.7%	93.9%	97.0%
GSR 8: CCI, MCW	181	92.3%	61.3%	94.5%	84.0%
GSR 9: CCI, Inclusa, LCI	96	97.9%	71.9%	96.9%	97.9%

Care Coordination					
FC GSRs	**Records**	**Indicator Identification**			
MCOs Serving Each GSR	*Number Reviewed*	*3A*	*3B*	*3C*	*3D*
GSR 10: CCI, Inclusa, LCI	72	94.4%	63.9%	97.2%	93.1%
GSR 11: CCI, Inclusa, MCW	61	96.7%	70.5%	91.8%	86.9%
GSR 12: CCI, MCW	46	95.7%	54.3%	93.5%	87.0%
GSR 13: Inclusa, LCI	133	95.5%	68.4%	98.5%	94.0%
GSR 14: Inclusa, MCW	14	92.9%	42.9%	100.0%	78.6%
Total	**1,057**	**95.1%**	**64.0%**	**96.3%**	**89.4%**

Please see Appendix 6 for a MCO comparison of the results of this focus area for each MCO operating the FC program in FY 23-24.

FCP

The *Timely Coordination (3A)* indicator evaluates plans put in place by the IDT to ensure member needs and supports are coordinated effectively and in a timely manner. Results for the indicator on a per record basis indicated strong practices. Results from prior reviews are not comparable, as the threshold to determine compliance changed. In prior reviews coordination was expected within 30 calendar days. The threshold changed to the end of the month following identification of the need in FY 23-24. All but one FCP GSR demonstrated strong practices. FCP GSR 11 indicated an opportunity for improvement.

The indicator *Timely Follow-Up (3B)* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Results for the indicator on a per record basis indicated a need for improvement. Results from prior reviews are not comparable, as the threshold to determine compliance changed. In prior reviews follow-up was expected within 30 calendar days. The threshold changed to the end of the month following identification of the need in FY 23-24.

Records found not met most often did not include evidence of follow-up for member's medical appointments. Most FCP GSRs indicated opportunities for improvement.

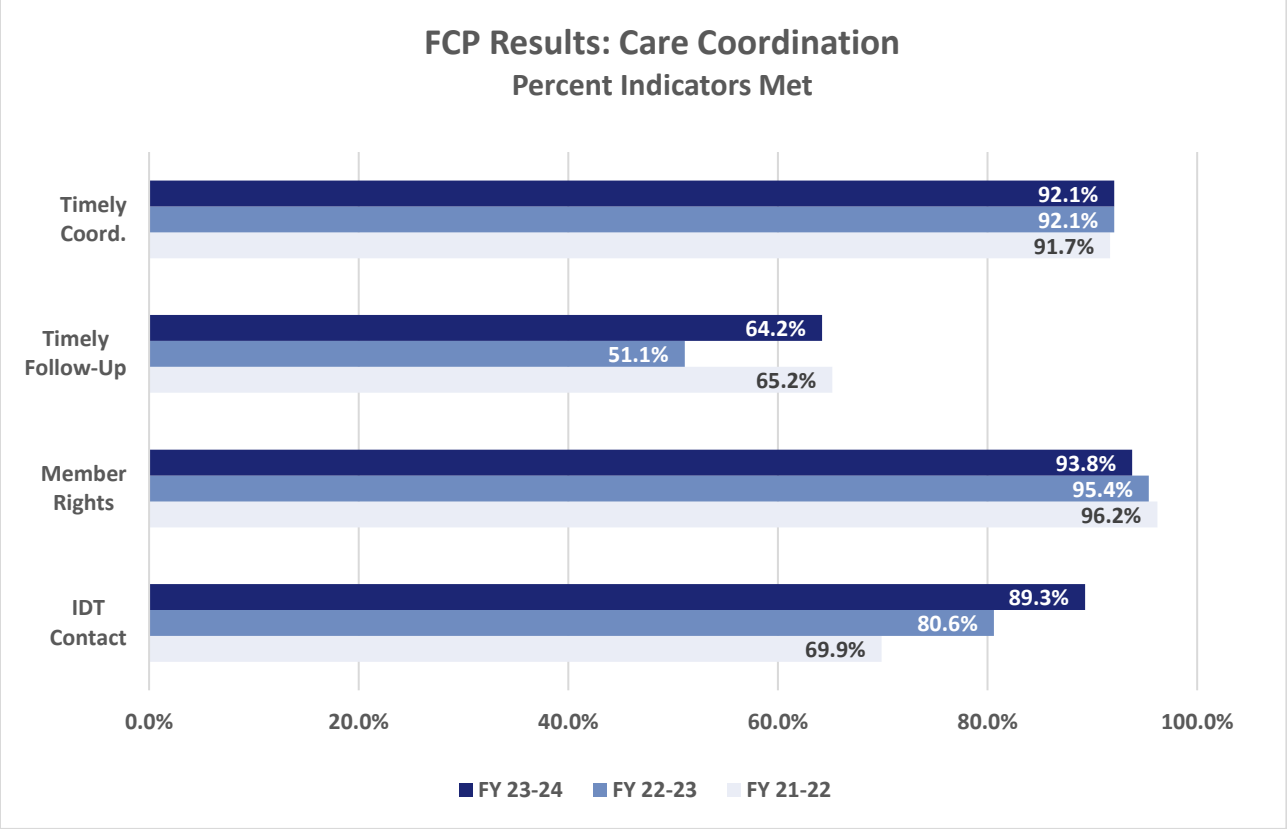
The indicator *Member Rights (3C)* evaluates the protection of member rights, such as IDT staff including the member and his/her supports in care management processes; offering and explaining the SDS option to the member; and following applicable guidelines for restrictive measures and rights limitations. Results for the indicator on a per record basis were similar to the prior review and demonstrated strengths. Analysis indicated the year-to-year difference in

the rates is likely due to normal variation or chance. All but two FCP GSRs demonstrated strong practices. FCP GSRs 8 and 13 indicated an opportunity for improvement.

The evaluation of IDT contact requirements under the indicator *IDT Contact (3D)*, included monthly collateral contacts, face-to-face 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 on a per record basis indicated opportunities for improvement. Results from prior reviews are not comparable, as new requirements for members residing in one and two bed adult family homes was included in the evaluation in FY 23-24.

Records not meeting requirements most often did not include evidence of a monthly telephone contact with the member, legal decision maker, or other appropriate person. Evidence of an in-person contact with the member every three months was another common reason for records to be not met. FCP GSRs 5, 12, and 13 indicated the most need for improvement. FCP GSRs 3, 6, 8, 9, 10, and 11 demonstrated strong practices.

Results for Care Coordination for MCOs Operating FCP:



The table below displays the results for this focus area by each FCP GSR in FY 23-24.

Care Coordination					
FCP GSRs	**Records**	**Indicator Identification**			
MCOs Serving Each GSR	*Number Reviewed*	*3A*	*3B*	*3C*	*3D*
GSR 3: MCW	2	100.0%	100.0%	100.0%	100.0%
GSR 5: MCW	31	90.3%	61.3%	90.3%	87.1%
GSR 6: CCI, MCW	42	97.6%	78.6%	97.6%	95.2%
GSR 8: CCI, *i*Care*	85	90.6%	64.7%	87.1%	91.8%
GSR 9: MCW	2	100.0%	0.0%	100.0%	100.0%
GSR 10: CCI	33	100.0%	78.8%	100.0%	97.0%
GSR 11: CCI, *i*Care*	44	86.4%	70.5%	97.7%	100.0%
GSR 12: *i*Care*, MCW	173	91.3%	58.4%	94.8%	82.7%
GSR 13: MCW	5	100.0%	0.0%	80.0%	80.0%
Totals**	**419**	**92.1%**	**64.2%**	**93.8%**	**89.3%**

**Note: iCare was not evaluated in FY 23-24.*
***Note: Two FCP members resided outside of the FCP GSRs and are included in the total, but not added to a specific GSR above.*

Please see Appendix 6 for an MCO comparison of the results of this focus area for each MCO operating the FCP program in FY 23-24.

PACE

The *Timely Coordination (3A)* indicator evaluates plans put in place by the IDT to ensure member needs and supports are coordinated effectively and in a timely manner. Results for the indicator on a per record basis indicated strong practices. Results from prior reviews are not comparable, as the threshold to determine compliance changed. In prior reviews coordination was expected within 30 calendar days. The threshold changed to the end of the month following identification of the need in FY 23-24. All PACE GSRs demonstrated strong practices, with all scoring above 90 percent.

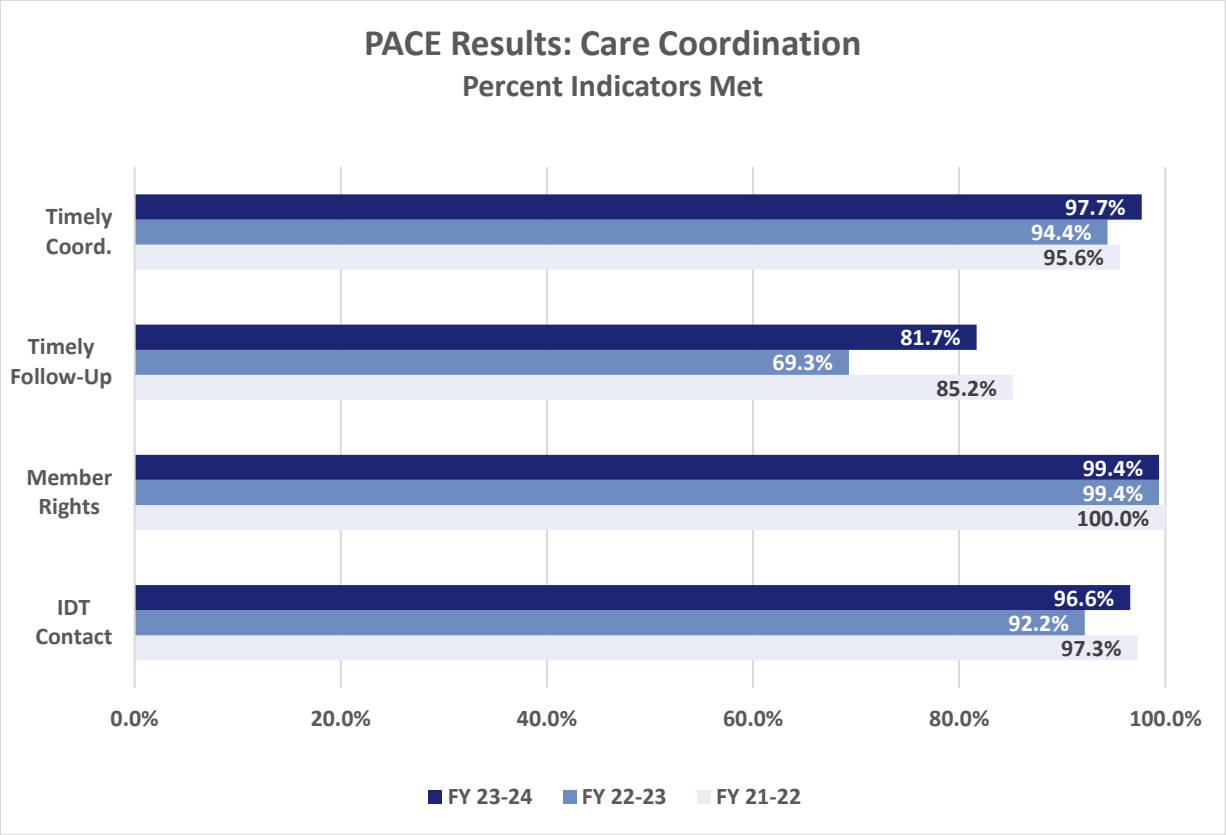
The indicator *Timely Follow-Up (3B)* evaluates whether the IDT followed up with members to confirm services and supports were received and effective. Results for the indicator on a per record basis indicated a need for improvement. Results from prior reviews are not comparable, as the threshold to determine compliance changed. In prior reviews follow-up was expected within 30 calendar days. The threshold changed to the end of the month following identification of the need in FY 23-24.

Follow-up to member medical appointments and DME was often not evidenced in the record and were the primary reasons for records to be scored not met. All PACE GSRs indicated opportunities for improvement.

The indicator *Member Rights (3C)* 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 on a per record basis 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. All PACE GSRs demonstrated strong practices, with all scoring above 90 percent.

The evaluation of IDT contact requirements under the indicator *IDT Contact (3D)*, included monthly collateral contacts, face-to-face 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 on a per record basis demonstrated strengths. Results from prior reviews are not comparable, as new requirements for members residing in one and two bed adult family homes was included in the evaluation in FY 23-24. Most PACE GSRs demonstrated strong practices.

Results for Care Coordination for MCOs Operating PACE:



The table below displays the results for this focus area by each PACE GSR in FY 23-24.

Care Coordination					
PACE GSRs	**Records**	**Indicator Identification**			
MCOs Serving Each GSR	*Number Reviewed*	*3A*	*3B*	*3C*	*3D*
GSR 6: CCI	28	100.0%	85.7%	100.0%	89.3%
GSR 8: CCI	121	97.5%	83.5%	99.2%	98.3%
GSR 11: CCI	25	96.0%	68.0%	100.0%	96.0%
Totals*	**175**	**97.7%**	**81.7%**	**99.4%**	**96.6%**

**Note: One PACE member resided outside of the PACE GSRs and is included in the total, but not added to a specific GSR above.*

CCI is the only MCO operating the PACE program; therefore, there are no MCO level comparisons.

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

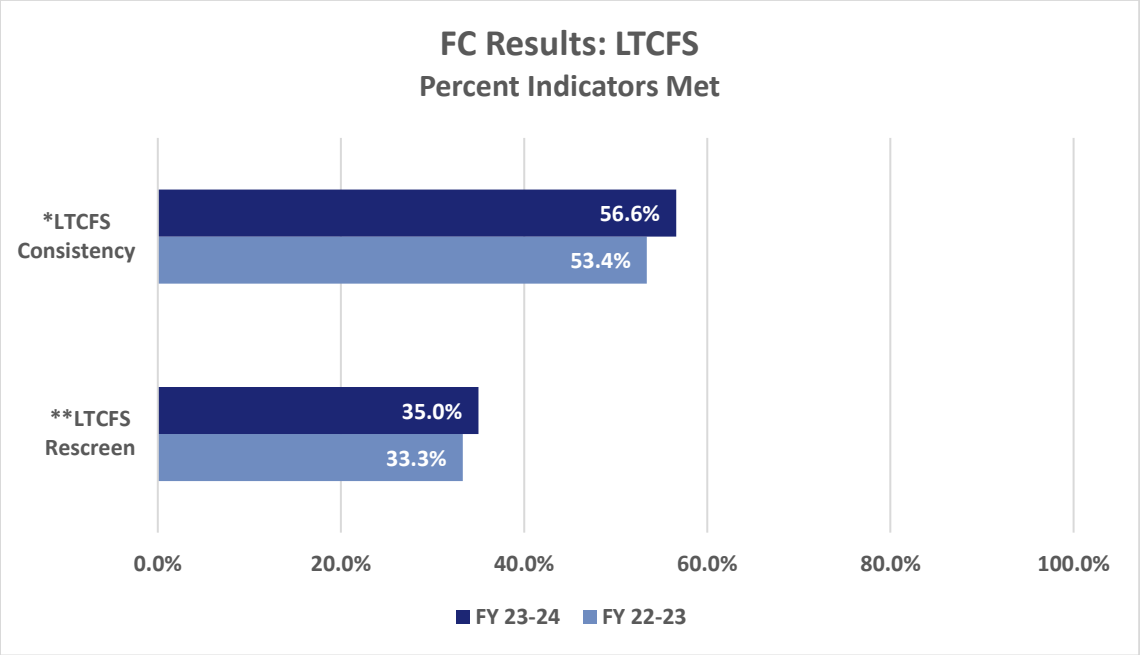
The indicator *LTCFS Consistency (4A)* evaluates the consistency between documentation on the member's LTCFS and the member's record (assessment or MCP). Results for the indicator on a per record basis indicated a need for improvement. Results from prior reviews are not comparable, as the criteria for inclusion in the indicator as well as the threshold to determine compliance changed.

Inconsistencies were most often identified with toileting DME, and exercise/range of motion (ROM), which is a health related service (HRS). All FC GSRs indicated opportunities for improvement.

The indicator *LTCFS Rescreen (4B)* evaluates if the MCO completed a rescreen when needed for a change in a member's needs. Results for the indicator on a per record basis indicated a need for improvement. Results from prior reviews are not comparable, as the threshold to determine compliance changed.

In all cases not met, the MCO did not rescreen following a change in the member's condition. Changes were most often related to starting or ending skilled therapies, or the need for DME. All FC GSRs indicated opportunities for improvement.

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



*Note: The review indicator *LTCFS Consistency* applied to 1,061 of 1,061 records in FY 22-23, and 821 of 1,057 records in FY 23-24. This was a newly evaluated requirement in FY 22-23 and there are no results from FY 21-22 to compare for this indicator.
**Note: The review indicator *LTCFS Rescreen* applied to 99 of 1,061 records in FY 22-23, and 80 of 1,057 records in FY 23-24. This was a newly evaluated requirement in FY 22-23 and there are no results from FY 21-22 to compare for this indicator.

The table below displays the results for this focus area by each FC GSR in FY 23-24.

Long Term Care Functional Screen			
FC GSRs	**Records**	**Indicator Identification**	
MCOs Serving Each GSR	*Number Reviewed*	*4A*	*4B*
GSR 1: Inclusa, MCW	85	51.5%	44.4%
GSR 2: Inclusa, MCW	85	47.3%	16.7%
GSR 3: Inclusa, MCW	37	48.3%	50.0%
GSR 4: Inclusa, LCI	91	43.9%	22.2%
GSR 5: Inclusa, MCW	57	57.1%	0.0%
GSR 6: CCI, Inclusa, MCW	99	72.7%	41.7%
GSR 8: CCI, MCW	181	60.7%	50.0%
GSR 9: CCI, Inclusa, LCI	96	68.7%	40.0%
GSR 10: CCI, Inclusa, LCI	72	62.7%	40.0%
GSR 11: CCI, Inclusa, MCW	61	65.3%	33.3%

Long Term Care Functional Screen			
FC GSRs	**Records**	**Indicator Identification**	
MCOs Serving Each GSR	*Number Reviewed*	*4A*	*4B*
GSR 12: CCI, MCW	46	38.2%	50.0%
GSR 13: Inclusa, LCI	133	52.3%	28.6%
GSR 14: Inclusa, MCW	14	41.7%	0.0%
Totals	**1,057**	**56.6%**	**35.0%**

Please see Appendix 6 for an MCO comparison of the results of this focus area for each MCO operating the FCP program in FY 23-24.

FCP

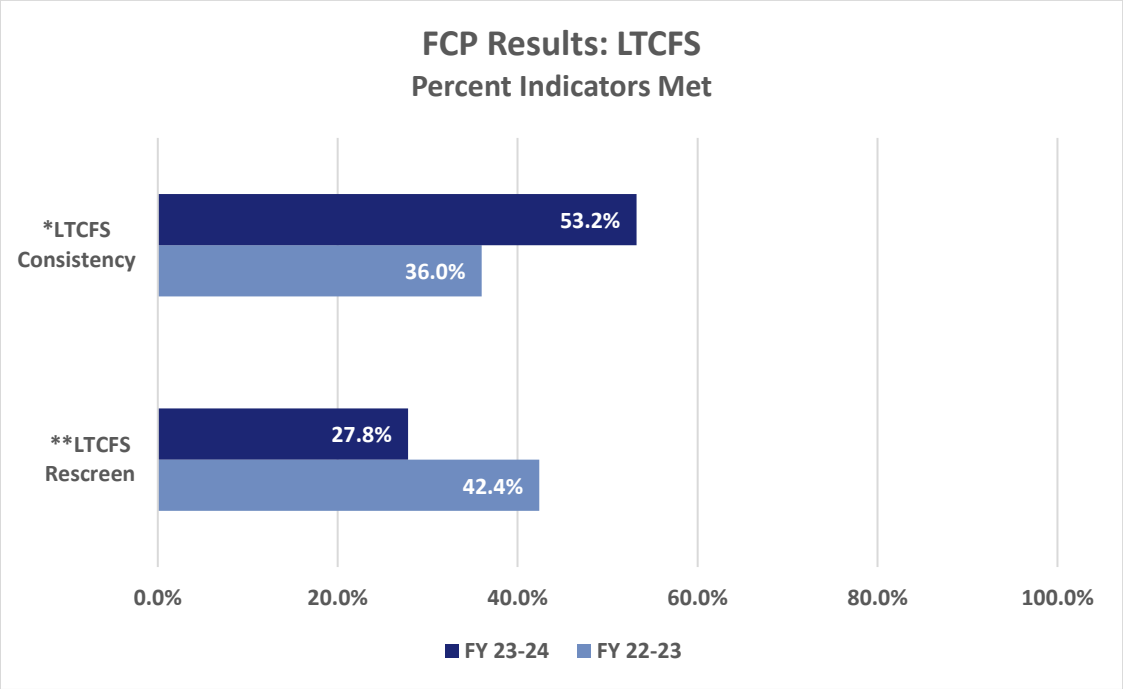
The indicator *LTCFS Consistency (4A)* evaluates the consistency between documentation on the member's LTCFS and the member's record (assessment or MCP). Results for the indicator on a per record basis indicated a need for improvement. Results from prior reviews are not comparable, as the criteria for inclusion in the indicator as well as the threshold to determine compliance changed.

Inconsistencies were most often identified with toileting DME and exercise/ROM, a HRS. All FCP GSRs indicated opportunities for improvement.

The indicator *LTCFS Rescreen (4B)* evaluates if the MCO completed a rescreen when needed for a change in a member's needs. Results for the indicator on a per record basis indicated opportunities for improvement. Results from prior reviews are not comparable, as the threshold to determine compliance changed.

In all cases not met, the MCO did not rescreen following a change in the member's condition. Changes were most often related to starting or ending skilled therapies. All FCP GSRs indicated opportunities for improvement.

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



*Note: The review indicator *LTCFS Consistency* applied to 655 of 655 records in FY 22-23, and 308 of 419 records in FY 23-24. This was a newly evaluated requirement in FY 22-23 and there are no results from FY 21-22 to compare for this indicator.
**Note: The review indicator *LTCFS Rescreen* applied to 59 of 655 records in FY 22-23, and 54 of 419 records in FY 23-24. This was a newly evaluated requirement in FY 22-23 and there are no results from FY 21-22 to compare for this indicator.

The table below displays the results for this focus area by each FCP GSR in FY 23-24.

Long Term Care Functional Screen			
FCP GSRs	**Records**	**Indicator Description**	
MCOs Serving Each GSR	*Number Reviewed*	*4A*	*4B*
GSR 3: MCW	2	0.0%	0.0%
GSR 5: MCW	31	57.9%	75.0%
GSR 6: CCI, MCW	42	73.3%	0.0%
GSR 8: CCI, *i*Care*	85	55.2%	15.4%
GSR 9: MCW	2	50.0%	0.0%
GSR 10: CCI	33	86.2%	60.0%
GSR 11: CCI, *i*Care*	44	74.2%	37.5%
GSR 12: *i*Care*, MCW	173	36.4%	23.5%
GSR 13: MCW	5	20.0%	0.0%

Long Term Care Functional Screen			
FCP GSRs	**Records**	**Indicator Description**	
MCOs Serving Each GSR	*Number Reviewed*	*4A*	*4B*
Totals**	**419**	**53.2%**	**27.8%**

**Note: iCare was not evaluated in FY 23-24.*
***Note: Two FCP members resided outside of the FCP GSRs and are included in the total, but not added to a specific GSR above.*

Please see Appendix 6 for an MCO comparison of the results of this focus area for each MCO operating the FCP program in FY 23-24.

PACE

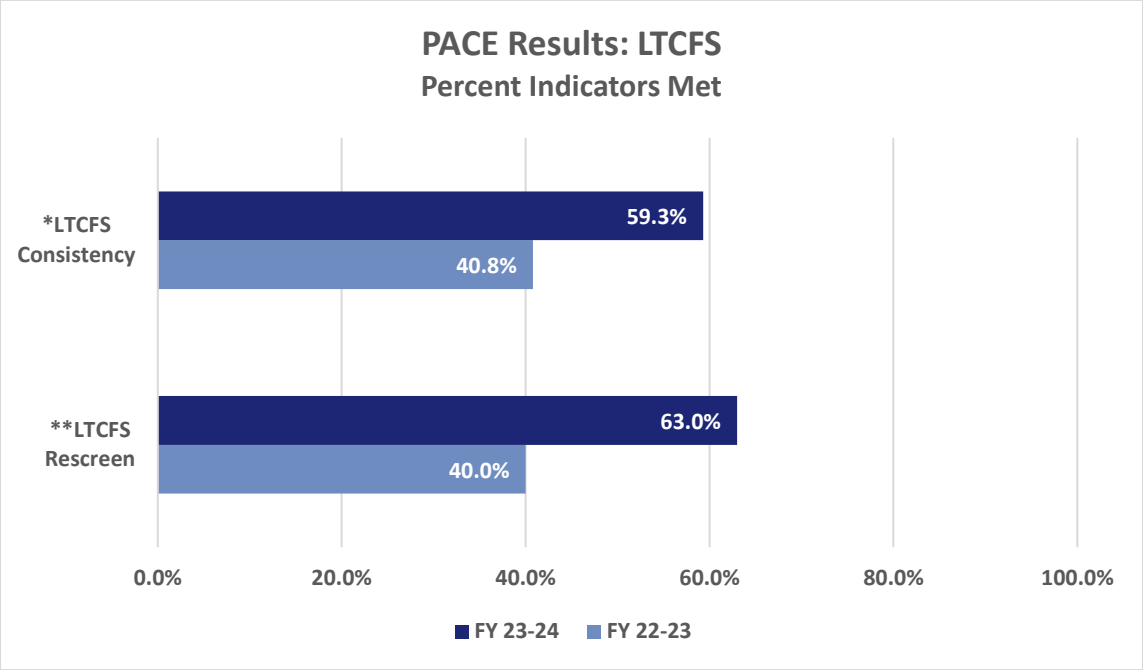
The indicator *LTCFS Consistency (4A)* evaluates the consistency between documentation on the member's LTCFS and the member's record (assessment or MCP). Results for the indicator on a per record basis indicated a need for improvement. Results from prior reviews are not comparable, as the criteria for inclusion in the indicator as well as the threshold to determine compliance changed.

Inconsistencies were most often identified with exercise/ROM, a HRS. All PACE GSRs indicated opportunities for improvement.

The indicator *LTCFS Rescreen (4B)* evaluates if the MCO completed a rescreen when needed for a change in a member's needs. Results for the indicator on a per record basis indicated opportunities for improvement. Results from prior reviews are not comparable, as the threshold to determine compliance changed.

In most cases found not met, the MCO did not rescreen when a member received a new service or support, such as skilled therapies or wound care. PACE GSRs 8 and 11 indicated opportunities for improvement, while PACE GSR 6 demonstrated strong practices.

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



*Note: The review indicator *LTCFS Consistency* applied to 179 of 179 records in FY 22-23, and 118 of 175 records in FY 23-24. This was a newly evaluated requirement in FY 22-23 and there are no results from FY 21-22 to compare for this indicator.
**Note: The review indicator *LTCFS Rescreen* applied to 30 of 179 records in FY 22-23, and 27 of 175 records in FY 23-24. This was a newly evaluated requirement in FY 22-23 and there are no results from FY 21-22 to compare for this indicator.

The table below displays the results for this focus area by each PACE GSR in FY 23-24.

Long Term Care Functional Screen			
PACE GSRs	**Records**	**Indicator Description**	
MCOs Serving Each GSR	*Number Reviewed*	*4A*	*4B*
GSR 6: CCI	28	61.1%	100.0%
GSR 8: CCI	121	63.4%	52.9%
GSR 11: CCI	25	41.2%	60.0%
Totals*	**175**	**59.3%**	**63.0%**

**Note: One PACE member resided outside of the PACE GSRs and is included in the total, but not added to a specific GSR above.*

CCI is the only MCO operating the PACE program; therefore, there are no MCO level comparisons.

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.

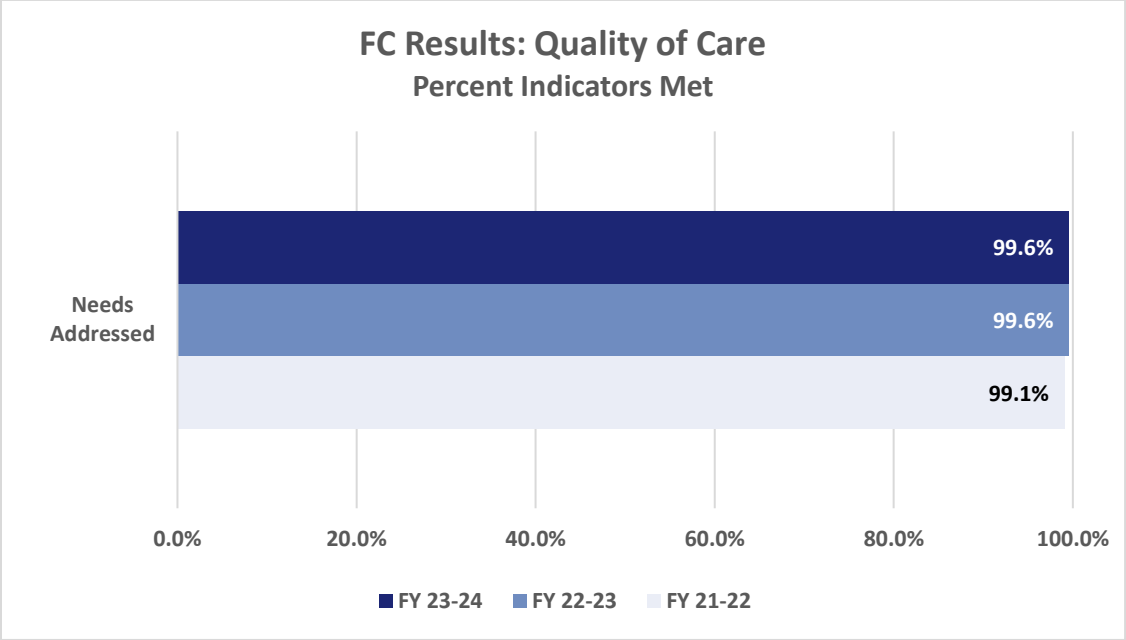
FC

The indicator *Quality of Care (5)* evaluates the MCO's responsibility to assure all health, safety, and welfare needs of the member are adequately supported. Results for the indicator on a per record basis 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. All FC GSRs demonstrated strong practices, with all scoring above 90 percent.

The table below page identifies FC members referred to DHS for additional oversight and monitoring and which category of referral applied.

Quality of Care Referrals FC			
Member Referral Categories	**FY 21-22** *1,051*	**FY 22-23** *1,061*	**FY 23-24** *1,057*
Health and Safety Concerns	0	0	0
Complex or Challenging Situations	4	0	1
Use of Personal Resources	4	4	3

Results for Quality of Care for MCOs Operating FC:



The table below displays the results for this focus area by each FC GSR in FY 23-24.

Quality of Care		
FC GSRs	**Records**	**Indicator Identification**
MCOs Serving Each GSR	*Number Reviewed*	*5*
GSR 1: Inclusa, MCW	85	100.0%
GSR 2: Inclusa, MCW	85	100.0%
GSR 3: Inclusa, MCW	37	97.3%
GSR 4: Inclusa, LCI	91	100.0%
GSR 5: Inclusa, MCW	57	100.0%
GSR 6: CCI, Inclusa, MCW	99	100.0%
GSR 8: CCI, MCW	181	98.9%
GSR 9: CCI, Inclusa, LCI	96	100.0%
GSR 10: CCI, Inclusa, LCI	72	100.0%
GSR 11: CCI, Inclusa, MCW	61	98.4%
GSR 12: CCI, MCW	46	100.0%
GSR 13: Inclusa, LCI	133	100.0%
GSR 14: Inclusa, MCW	14	100.0%
Totals	**1,057**	**99.6%**

Please see Appendix 6 for an MCO comparison of the results of this focus area for each MCO operating the FC program in FY 23-24.

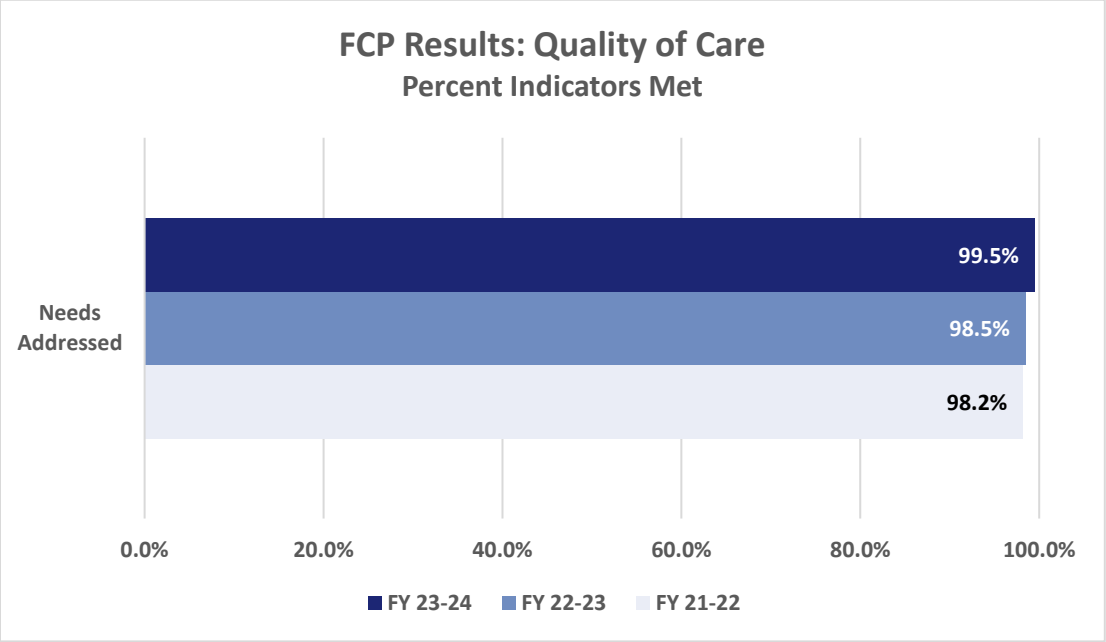
FCP

The indicator *Quality of Care (5)* evaluates the MCO's responsibility to assure all health, safety, and welfare needs of the member are adequately supported. Results for the indicator on a per record basis 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. All FCP GSRs demonstrated strong practices, with all scoring above 90 percent.

The table below identifies FCP members referred to DHS for additional oversight and monitoring and which category of referral applied.

Quality of Care Referrals FCP			
Member Referral Categories	**FY 21-22** *652*	**FY 22-23** *655*	**FY 23-24** *419*
Health and Safety Concerns	0	0	0
Complex or Challenging Situations	2	1	0
Use of Personal Resources	10	9	2

Results for Quality of Care for MCOs Operating FCP:



The table below displays the results for this focus area by each FCP GSR in FY 23-24.

Quality of Care		
FCP GSRs	**Records**	**Indicator Identification**
MCOs Serving Each GSR	*Number Reviewed*	*5*
GSR 3: MCW	2	100.0%
GSR 5: MCW	31	96.8%
GSR 6: CCI, MCW	42	100.0%
GSR 8: CCI, *i*Care*	85	100.0%
GSR 9: MCW	2	100.0%
GSR 10: CCI	33	100.0%
GSR 11: CCI, *i*Care*	44	100.0%
GSR 12: *i*Care*, MCW	173	99.4%
GSR 13: MCW	5	100.0%
Totals**	**419**	**99.5%**

**Note: iCare was not evaluated in FY 23-24.*

***Note: Two FCP members resided outside of the FCP GSRs and are included in the total, but not added to a specific GSR above.*

Please see Appendix 6 for an MCO comparison of the results of this focus area for each MCO operating the FCP program in FY 23-24.

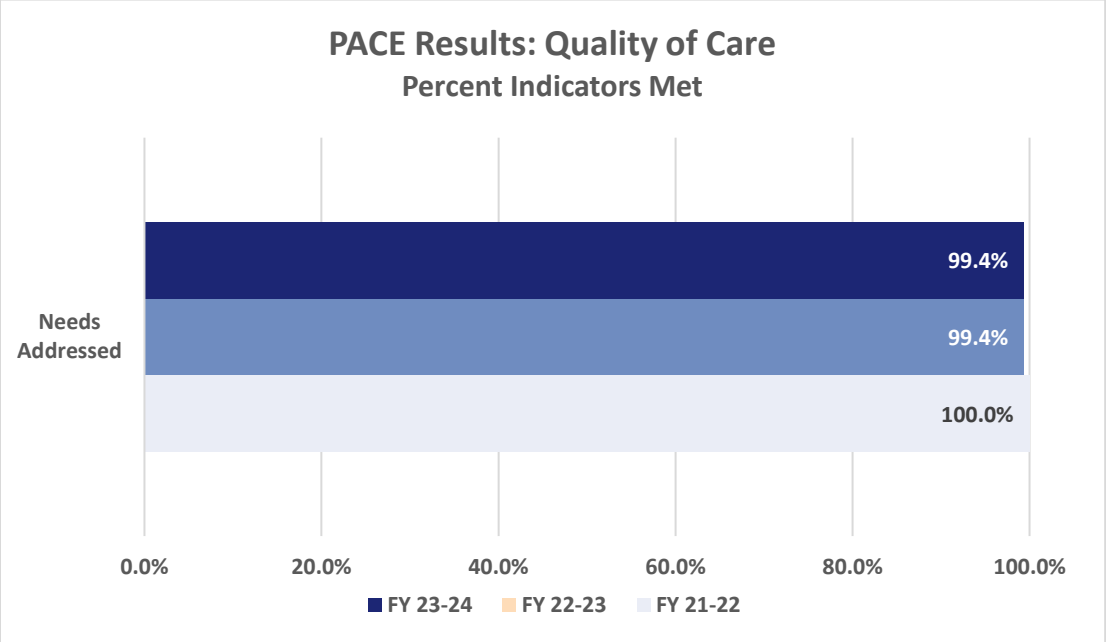
PACE

The indicator *Quality of Care (5)* evaluates the MCO's responsibility to assure all health, safety, and welfare needs of the member are adequately supported. Results for the indicator on a per record basis were similar to the prior review and demonstrated strong practices. Analysis indicated the year-to-year difference in the rates is likely due to normal variation or chance. All PACE GSRs demonstrated strong practices, with all scoring above 90 percent.

The table below identifies PACE members referred to DHS for additional oversight and monitoring and which category of referral applied.

Quality of Care Referrals PACE			
Member Referral Categories	**FY 21-22** *182 Records*	**FY 22-23** *179 Records*	**FY 23-24** *175 Records*
Health and Safety Concerns	0	0	0
Complex or Challenging Situations	0	0	0
Use of Personal Resources	0	1	1

Results for Quality of Care for MCOs Operating PACE:



The table below displays the results for this focus area by each PACE GSR in FY 23-24.

Quality of Care		
PACE GSRs	**Records**	**Indicator Identification**
MCOs Serving Each GSR	*Number Reviewed*	*5*
GSR 6: CCI	28	100.0%
GSR 8: CCI	121	99.2%
GSR 11: CCI	25	100.0%
Totals*	**175**	99.4%

**Note: One PACE member resided outside of the PACE GSRs and is included in the total, but not added to a specific GSR above.*

CCI is the only MCO operating the PACE program; therefore, there are no MCO level comparisons.

Analysis

Aggregate results for all programs indicated a high level of compliance. 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 Assessment*, *Comprehensive MCP*, *Timely MCP*, *Essential Providers*, *Timely Follow-Up, IDT Contact, LTCFS Consistency*, and *LTCFS Rescreen*. Analysis by GSR identifies areas of focus for each CMR indicator. Using the statewide rates for FC as the benchmark:

- The results for seven GSRs are below the statewide rate for *Comprehensive Assessment* (75.9 percent): GSRs 1, 2, 3, 4, 5, 11, and 14.
- The results for seven GSRs are below the statewide rate for *Comprehensive MCP* (67.1 percent): GSRs 1, 2, 3, 4, 10, 11, and 14.
- The results for six GSRs are below the statewide rate for *Timely MCP* (82.6 percent): GSRs 1, 4, 6, 8, 11, and 12.
- The results for seven GSRs are below the statewide rate for *Essential Providers* (83.2 percent): GSRs 1, 2, 3, 6, 8, 11, and 14.
- The results for eight GSRs are below the statewide rate for *Timely Follow-Up* (64.0 percent): GSRs 1, 2, 3, 5, 8, 10, 12, and 14.
- The results for seven GSRs are below the statewide rate for *IDT Contact* (89.4 percent): GSRs 1, 2, 5, 8, 11, 12, and 14.
- The results for seven GSRs are below the statewide rate for *LTCFS Consistency* (56.6 percent): GSRs 1, 2, 3, 4, 12, 13, and 14.
- The results for six GSRs are below the statewide rate for *LTCFS Rescreen* (35.0 percent): GSRs 2, 4, 5, 11, 13, and 14.

FCP

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

- The results for two GSRs are below the statewide rate for *Comprehensive Assessment* (85.7 percent): GSRs 8 and 13.
- The results for three GSRs are below the statewide rate for *Comprehensive MCP* (84.2 percent): GSRs 8, 11, and 13.

- The results for two GSRs are below the statewide rate for *Timely MCP* (82.1 percent): GSRs 8 and 13.
- The results for three GSRs are below the statewide rate for *Essential Providers* (87.0 percent): GSRs 8, 12, and 13.
- The results for four GSRs are below the statewide rate for *Timely Follow-Up* (64.2 percent): GSRs 5, 9, 12, and 13.
- The results for three GSRs are below the statewide rate for *IDT Contact* (89.3 percent): GSRs 5, 12, and 13.
- The results for four GSRs are below the statewide rate for *LTCFS Consistency* (53.2 percent): GSRs 3, 9, 12, and 13.
- The results for six GSRs are below the statewide rate for *LTCFS Rescreen* (27.8 percent): GSRs 3, 6, 8, 9, 12, and 13.

PACE

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

- The results for two GSRs are below the statewide rate for *Timely MCP* (89.7 percent): GSRs 6 and 11.
- The results for one GSR are below the statewide rate for *Timely Follow-Up* (81.7 percent): GSR 11.
- The results for one GSR are below the statewide rate for *LTCFS Consistency* (59.3 percent): GSR 11.
- The results for two GSRs are below the statewide rate for *LTCFS Rescreen* (63.0 percent): GSRs 8 and 11.

Progress on Previous EQRO Plan Level Recommendations

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

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

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

The table below identifies the recommendations made the by the EQRO in the prior review, FY 22-23, the actions taken by the MCO to address the recommendations, and the degree to which the MCO addressed the recommendations.

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCI	– Continue to focus efforts on improving comprehensiveness of assessments and member-centered plans in the Family Care and Family Care Partnership programs. – Develop and implement a consent form for members to receive electronic materials for all programs that includes options for all member materials. – 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. – Improve timeliness of follow-up for member needs and services in all programs, especially for medical appointments.	– The FC program improved the comprehensiveness of member-centered plans (MCPs), by ensuring all services and supports are included for all identified risks and assessed needs. – The FCP program improved practices to update the MCP when a member has a change in condition. – The FCP program demonstrated improvements in ensuring signatures for essential providers are obtained as required.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– 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.		
*i*Care	– 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.	– Not applicable. No review conducted due to merging operations of *i*Care and Inclusa.	Not Applicable

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Inclusa	– 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.	– No progress was identified.	Low
LCI	– Focus efforts on improving the comprehensiveness of member-centered plans. – Ensure all disenrollment policies include the requirement to assist members whose enrollment ceases for any reason in obtaining transitional care.	– No progress was identified.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– 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. – 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.		
MCW	– 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	– The organization improved the timeliness of MCP reviews in the FCP program.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	ensure routine contact occurs with members and other involved parties. – Focus efforts to increase the consistency in documentation between the *Adult Long Term Care Functional Screen* and the managed care organization documentation in both programs, and ensure rescreening is conducted when needed.		

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 23-24, MetaStar conducted ISCAs for two MCOs selected by DHS. The following MCOs and programs were evaluated:

Managed Care Organization	Program(s)
Community Care, Inc. (CCI)	FC; FCP; PACE
Inclusa, Inc. (Inclusa)	FC

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 each MCO's information management practices on data submitted to DHS. In addition to completing the ISCA scoring tool, MetaStar asked the MCOs to submit documentation specific to their IS and operations used to collect, process, and report data. Reviewers also conducted staff interviews and observed demonstrations of each 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 Appendix 2 for more information about the scoring methodology.

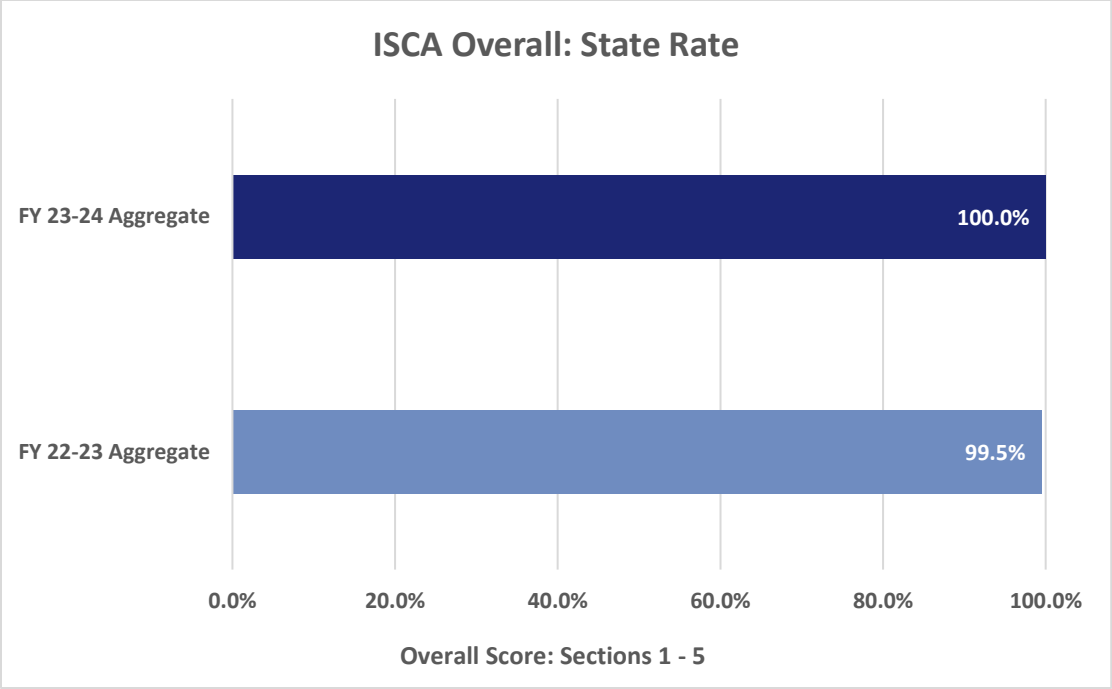
Scoring Legend		
Percentage Met	**Stars**	**Rating**
95.0% - 100.0%	★★★★★	Fully Met
90.0% - 94.9%	★★★★½	
85.0% - 89.9%	★★★★	Substantially Met
80.0% - 84.5%	★★★½	
75.0% - 79.9%	★★★	Partially Met
70.0% - 74.9%	★★½	
65.0% - 69.9%	★★	Minimally Met
60.0% - 64.9%	★½	
55.0%-59.9%	★	Not Met
< 55.0%	½	

Aggregately, the MCOs had an overall score of 100.0 percent, and a rating of Fully Met. 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.

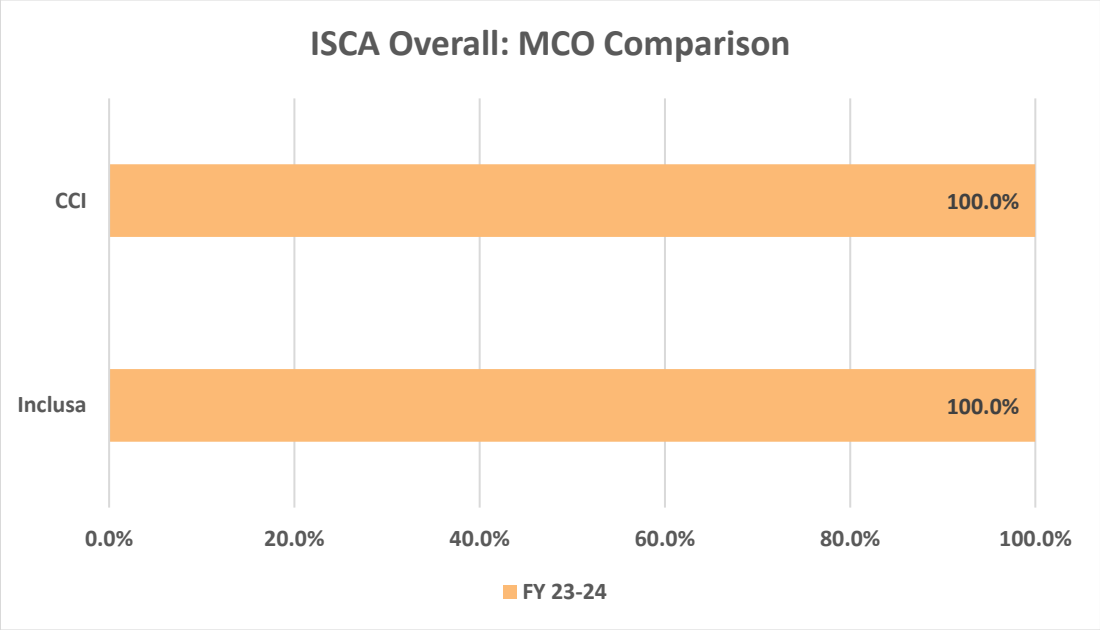
Information Systems Capabilities Assessment FY 22-23				
Focus Area	**Scoring Elements**	**Percentage Met**	**Stars**	**Rating**
Section 1: Background Information*	N/A	N/A	N/A	N/A
Section 2: Information Systems	48/48	100.0%	★★★★★	Fully Met
Section 3: Staffing	4/4	100.0%	★★★★★	Fully Met
Section 4: Security	54/54	100.0%	★★★★★	Fully Met
Section 5: Data Acquisition Capabilities	173/173	100.0%	★★★★★	Fully Met
Overall	**279/279**	**100.0%**	★★★★★	**Fully Met**

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 23-24 and compares the score to the overall compliance score from FY 22-23.



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



Results for each ISCA Focus Area

Observation and Analysis: Section 1. Background Information

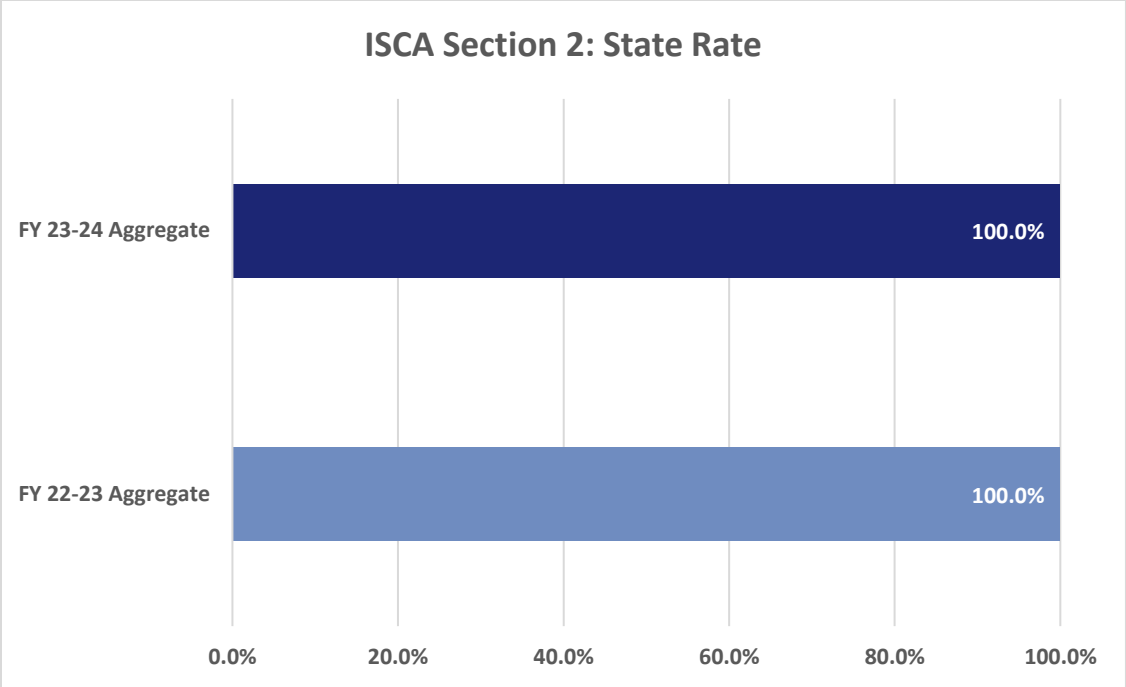
The MCOs detailed the type of managed care program operated by each MCO, the year the organizations were incorporated, average enrollment by program, and when the previous ISCAs were conducted. This section is for informational purposes only and is not included in the scoring calculations. The following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

MCO Background Information		
MCO	CCI	Inclusa
Date of Incorporation:	1977	2016
Date of Prior ISCA:	December 2020	December 2020

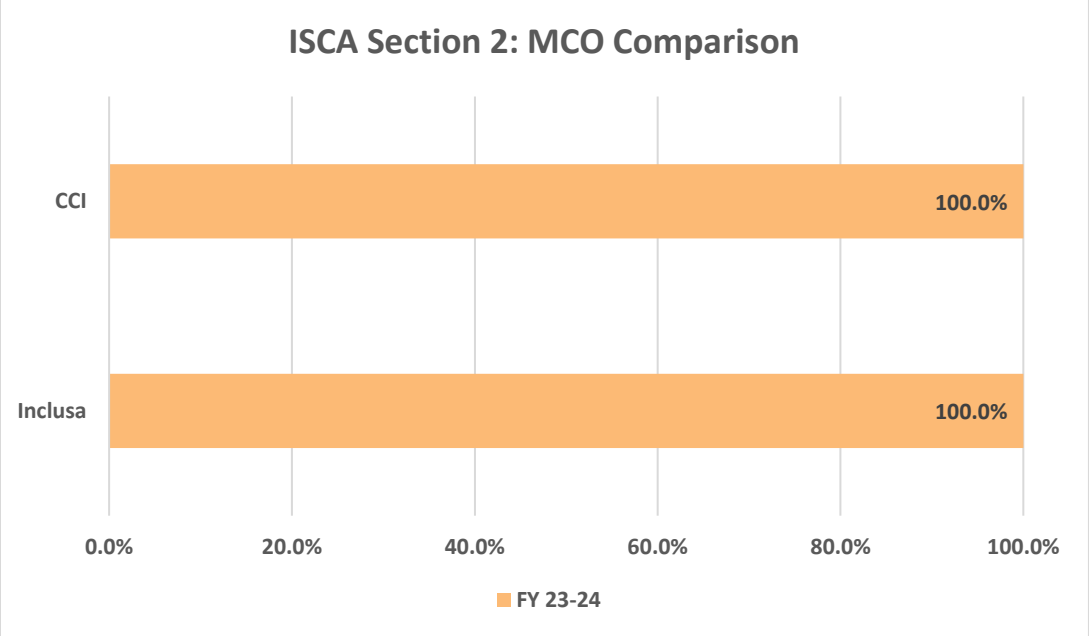
Observation and Analysis: Section 2. Information Systems - Data Processing & Personnel

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 24 possible scoring elements for each MCO. The MCOs satisfied requirements for 48 out of 48 scoring elements, for a score of 100.0 percent, and a rating of Fully Met.

The graph on the next page illustrates the State's overall compliance with these standards in FY 23-24 and compares the score to the overall compliance score from FY 22-23.



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



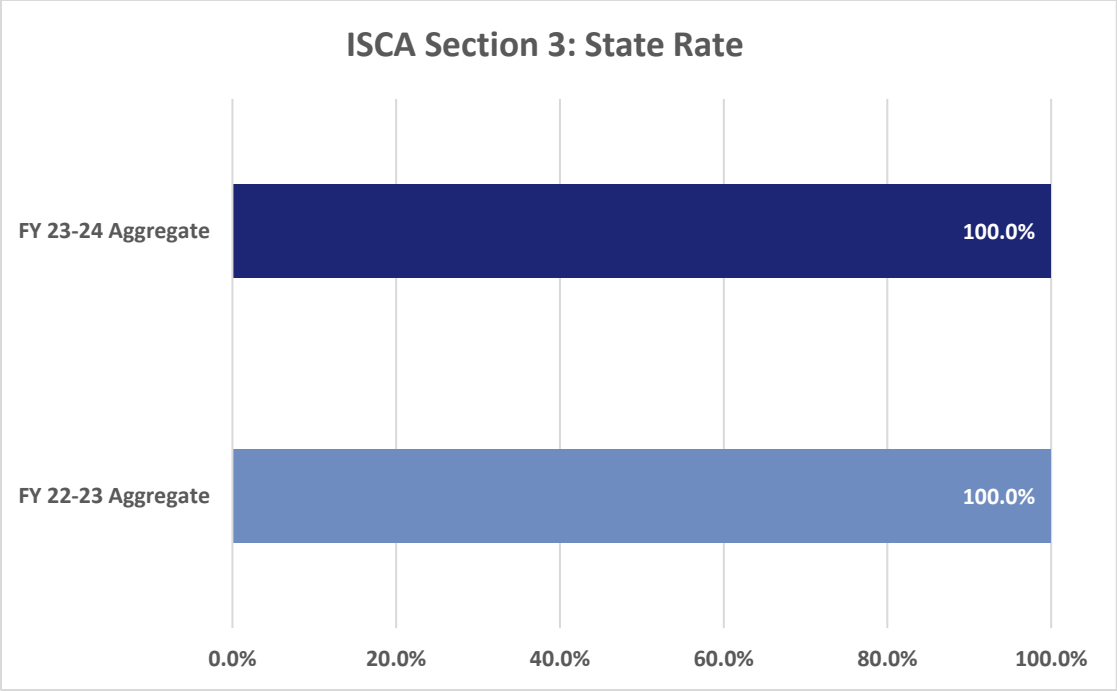
The responses submitted and interview sessions with MCO staff satisfied requirements of this focus area. Inclusa contracts with a third-party administrator (TPA) to gather and process claims, while CCI utilizes its own comprehensive and modular claims processing system to maintain the information necessary to support the MCO's key administrative functions.

Both 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 in a testing environment, and compare outputs to identify and address issues prior to production.

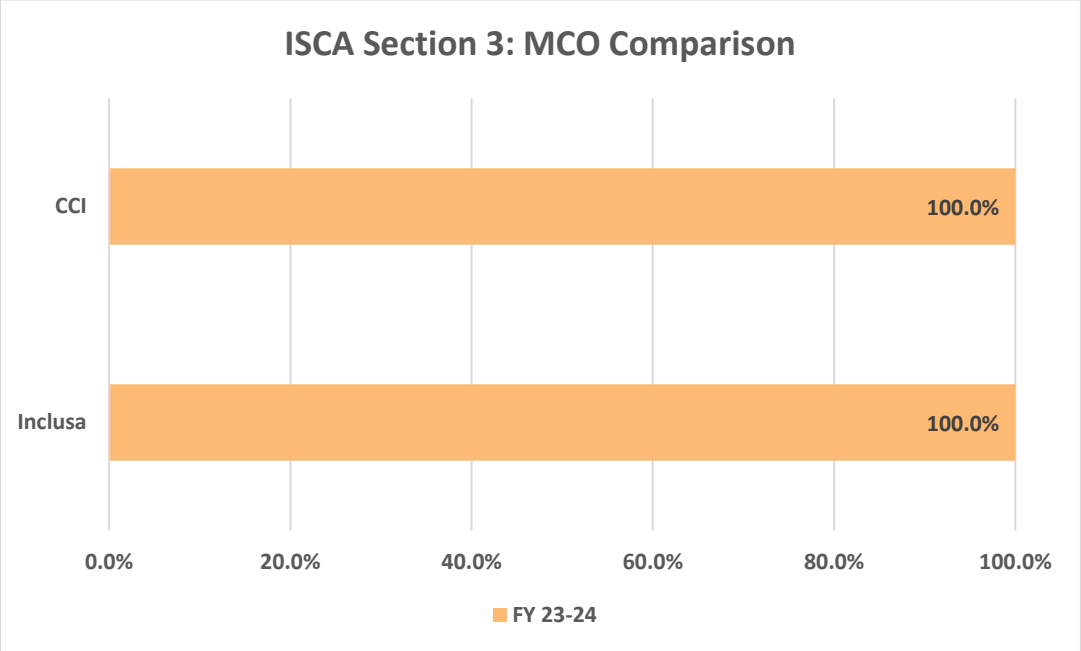
Observation and Analysis: Section 3. Staffing

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 Fully Met.

The graph on the next page illustrates the State's overall compliance with these standards in FY 23-24 and compares the score to the overall compliance score from FY 22-23.



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



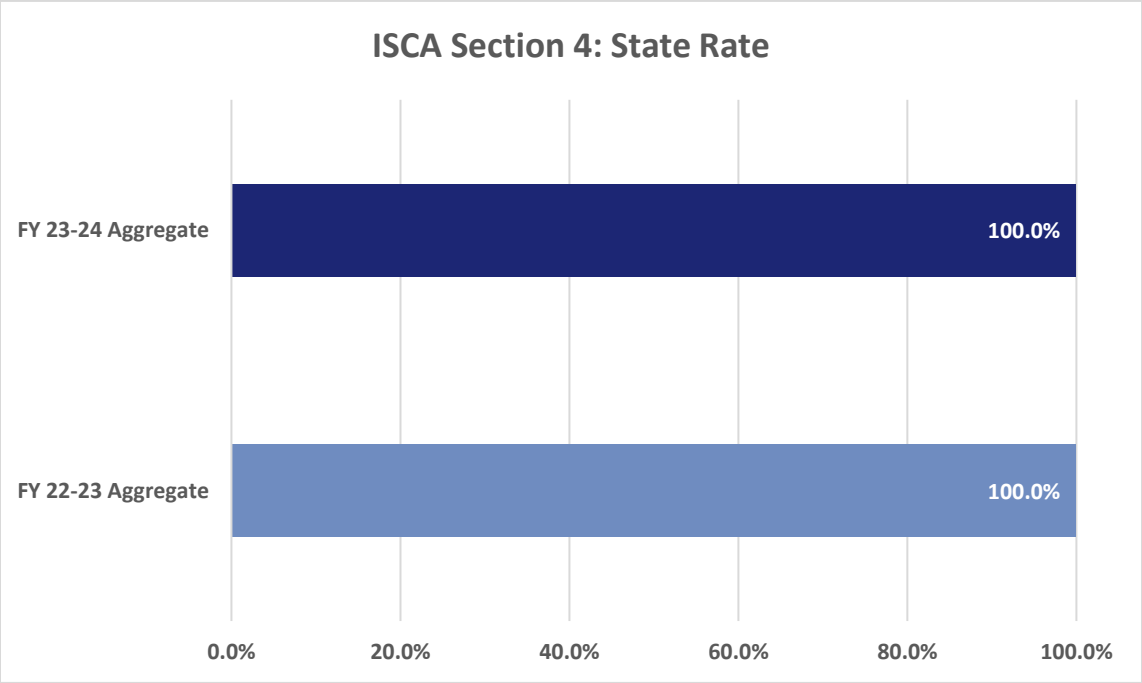
The responses submitted and interview sessions with MCO staff satisfied requirements of this focus area. Each MCO has a formal training program for new claims processing staff, or internal

new claims pend, claims adjustment, or claims correction staff. Work performed by new staff is audited daily until they sufficiently demonstrate they have mastered the skills needed for the assigned tasks. Ongoing standard audits occur, with supervisory or management staff providing coaching and additional training to all staff based on quality trends and frequently identified errors.

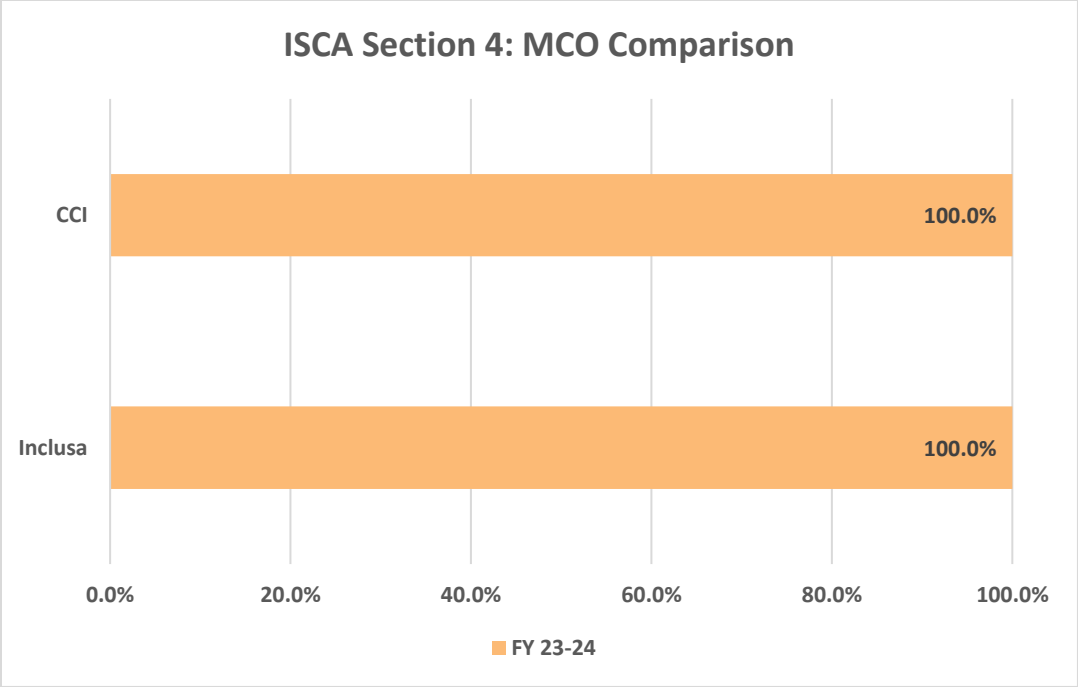
Observation and Analysis: Section 4. Security

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 27 possible scoring elements for each MCO. The MCOs satisfied requirements for 54 out of 54 scoring elements, for a score of 100.0 percent, and a rating of Fully Met.

The graph below illustrates the State's overall compliance with these standards in FY 23-24 and compares the score to the overall compliance score from FY 22-23.



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

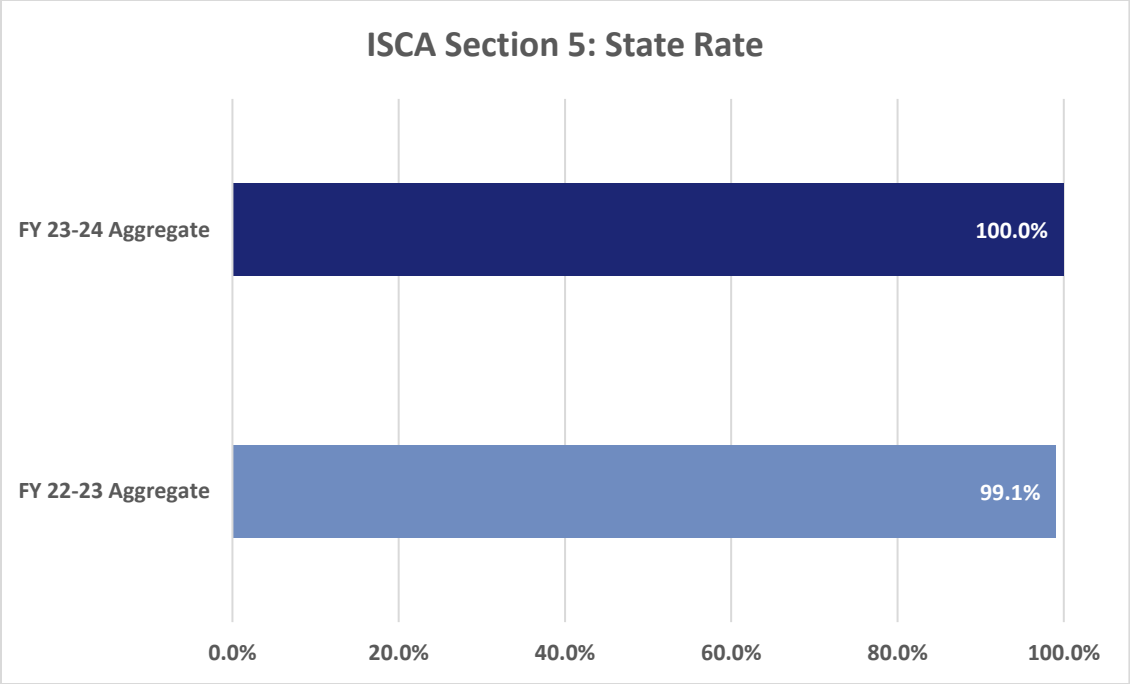


The responses submitted and interview sessions with MCO staff satisfied requirements of this focus area. Each organization has a disaster recovery system to enable each organization to keep business functions running in the event of a disaster or failover. A large majority of staff at each MCO continue to work remotely since the Coronavirus Disease-2019 (COVID-19) pandemic, and physical security of information remained a priority. Both organizations utilize software to configure endpoint protections, detect malware and potential email violations, and utilize multi-factor authentication processes for staff to access applications and services within each MCOs' networks via virtual private network connections. CCI also uses a secure container desk top that does not allow users to store any data on personal work computers, and does not leave any data in a cache on the computer when a session is ended.

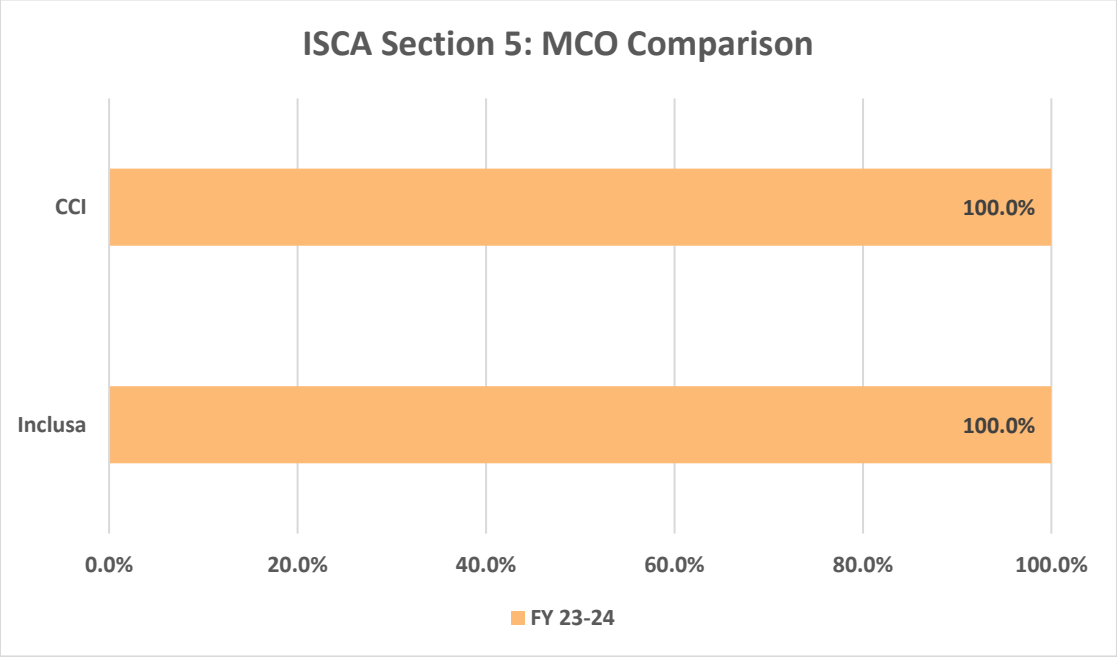
Observation and Analysis: Section 5. Data Acquisition Capabilities

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 contained 79 possible scoring elements for Inclusa and 94 possible scoring elements for CCI. Collectively, the MCOs satisfied all requirements, for a score of 100.0 percent, and a rating of Fully Met.

The graph on the next page illustrates the State's overall compliance with these standards in FY 23-24 and compares the score to the overall compliance score from FY 22-23.



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. CCI monitors claims inventory and aging through daily reports with routine audits completed monthly for each processor. A service level agreement is in place between the TPA and Inclusa which specifies expectations regarding accuracy and timeliness of claims processing. Auto-adjudication rates have been maintained since the previous year for both organizations, and validity edits are present within the claims processing system to ensure claims process efficiently.

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 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 met requirements of this focus area. CCI contracts with a TPA as its pharmacy benefit manager, and Inclusa imports data electronically from two state operated systems into is electronic care management system to supplement care management assessment practices. CCI holds monthly and quarterly meetings with the TPA to monitor and review data for validation purposes, and Inclusa monitors the accuracy of file transfers through the use of sanity checks.

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.

This section was only applicable to CCI, and the responses submitted and interview session with the organization met the requirements of this focus area. CCI accessed or received data from

two state operated systems to coordinate member are needs and determine appropriate supports. Data is not imported from these systems, but care teams reference the review of data for decision-making purposes.

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 met requirements of this focus area. Each organization's quality department staff extract vaccination data entered into their respective electronic care management systems for DHS performance measure reporting requirements. Both MCOs met all requirements for calculating and reporting measures.

Progress on Previous EQRO Plan Level Recommendations

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

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

The table below identifies the recommendations made the by the EQRO in the prior review, FY 20-21, the actions taken by the MCO to address the recommendations, and the degree to which the MCO addressed the recommendations.

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCI	The MCO satisfied all requirements. No recommendations for improvement were identified.	Not Applicable	Not Applicable
Inclusa	The MCO satisfied all requirements. No recommendation for improvement were identified.	Not Applicable	Not Applicable

Conclusions

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

Appendix 1 – List of Acronyms

ADL	Activity of Daily Living
CBRF	Community Based Residential Facility
CCI	Community Care, Inc., Managed Care Organization
CFR	Code of Federal Regulations
CHF	Congestive Heart Failure
CHIP	Children's Health Insurance Program
CMC	Children with Medical Complexity
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CPA	Certified Public Accountant
COVID-19	Coronavirus Disease-2019
DHS	Wisconsin Department of Health Services
DME	Durable Medical Equipment
DMS	Disposable Medical Supplies
EHR	Electronic Health Record
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Family Care
FCP	Family Care Partnership
FE	Frail Elder
FY	Fiscal Year
GAGAS	Generally Accepted Government Auditing Standards
GSR	Geographic Service Region
HCBS	Home and Community Based Services Waivers
HEDIS®[2]	Healthcare Effectiveness Data and Information Set

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

HRS	Heath Related Service
IADL	Instrumental Activity of Daily Living
*i*Care	Independent Care Health Plan, Managed Care Organization
I/DD	Intellectual/Developmental Disability
IDT	Interdisciplinary Team
Inclusa	Inclusa, Inc., Managed Care Organization
IS	Information System(s)
ISCA	Information Systems Capabilities Assessment
LTCFS	Wisconsin Long Term Care Functional Screen
LCI	Lakeland Care, Inc., Managed Care Organization
LTSS	Long-term services and supports
MCO	Managed Care Organization
MCP	Member-Centered Plan
MCW	My Choice Wisconsin, Inc., Managed Care Organization
MY	Measurement Year
N/A	Not Applicable
NAV	Network Adequacy Validation (Validation of Network Adequacy)
NCQA	National Committee for Quality Assurance
PACE	Program of All-Inclusive Care for the Elderly
PD	Physical Disability
PDSA	Plan-Do-Study-Act
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
RNCM	Registered Nurse Care Manager
ROM	Range of Motion
SDS	Self-Directed Supports
SHC	Supportive Home Care
TPA	Third-Party Administrator

Appendix 2 – Requirement for External Quality Review and Review Methodologies

Requirement for External Quality Review

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

MetaStar - Wisconsin's External Quality Review Organization

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

MetaStar conducts EQR of MCOs operating Medicaid managed long-term programs, including Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly. In addition, the company conducts EQR of MCOs serving BadgerCare Plus, Supplemental Security Income, Prepaid 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 Services 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®)[3] auditor, and information technologies staff.

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

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

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

Review Methodologies

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

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

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

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

The validity and reliability of the PIP methods and findings are assessed to determine whether the EQRO has confidence in the PIP results. The validation ratings reflect the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data

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

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

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

The methodology rating is based on the percentage of applicable scoring elements met for each standard. The findings were analyzed and compiled using a binomial structure (*met* and *not met*) to assess the organization's level of compliance with the PIP protocol standards, although some standards or associated indicators may have been scored *not applicable* due to the study design or phase of implementation at the time of the review. For any findings of *not met,* the EQR team documented the missing requirements related to the findings and provided recommendations. Each section has a specified number of scoring elements, which correlate with the *CMS EQR Protocol 1, Validation of Performance Improvement Projects.*

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

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

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

Validating performance measures is a mandatory EQR activity used to assess the accuracy of performance measures reported by the MCO, and to determine the extent to which performance measures calculated by the MCO follow state 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 conducted 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%	★★★★★	Fully Met
90.0% - 94.9%	★★★★½	
85.0% - 89.9%	★★★★	Substantially met
80.0% - 84.5%	★★★½	
75.0% - 79.9%	★★★	Partially Met
70.0% - 74.9%	★★½	
65.0% - 69.9%	★★	Minimally Met
60.0% - 64.9%	★½	

Scoring Legend		
Percentage Met	**Stars**	**Rating**
55.0%-59.9%	★	Not Met
< 55.0%	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 4: Validation of Network Adequacy

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

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

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

In January 2024, MetaStar used the information systems capabilities assessment (ISCA) scoring tool to collect information about the effect of the MCO's information management practices on encounter data submitted to DHS. Reviewers assessed information provided in the ISCA scoring tool, which was completed by the MCO and submitted to MetaStar. Some sections of the tool

may have been completed by contracted vendors, if directed by the MCO. Reviewers also obtained and evaluated additional supplemental documentation specific to the MCO's IS and organizational operations used to collect, process, and report claims and encounter data.

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

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

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 23-24 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 (IS) 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%	★★★★★	Fully Met
90.0% - 94.9%	★★★★½	
85.0% - 89.9%	★★★★	Substantially met
80.0% - 84.5%	★★★½	
75.0% - 79.9%	★★★	Partially Met
70.0% - 74.9%	★★½	
65.0% - 69.9%	★★	Minimally Met
60.0% - 64.9%	★½	
55.0% - 59.9%	★	Not Met
< 55.0%	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 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 23 - 24 MCO Comparative Scores

Standard	Citation	Managed Care Programs FY 23 - 24				
		CCI	Inclusa	*i*Care	LCI	MCW
Q1	*General rules - 42 CFR 438.330(a)*	100.0%	100.0%	87.5%	100.0%	87.5%
Q2	*Basic elements of the quality assessment and performance improvement program - 42 CFR 438.330(b)*	87.5%	100.0%	87.5%	87.5%	87.5%
Q3*	*Performance measurement - 42 CFR 438.330(c)*	NA	NA	NA	NA	NA
Q4*	*Performance improvement projects - 42 CFR 438.330(d)*	NA	NA	NA	NA	NA
Q5	*QAPI evaluations review - 42 CFR 438.330(e)(2)*	100.0%	100.0%	100%	100.0%	100.0%
Overall		**94.4%**	**100.0%**	**88.9%**	**94.4%**	**88.9%**

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

Standard	Citation	Managed Care Programs FY 23 - 24				
		CCI	Inclusa	*i*Care	LCI	MCW
G1	*Grievance systems - 42 CFR 438.228*	100.0%	100.0%	100.0%	100.0%	100.0%
G2	*General requirements - 42 CFR 438.402*	100.0%	100.0%	100.0%	100.0%	100.0%
G3	*Timely and adequate notice of adverse benefit determination - 42 CFR 438.404*	50.0%	75.0%	75.0%	75.0%	50.0%
G4	*Handling of grievances and appeals - 42 CFR 438.406*	100.0%	100.0%	100.0%	100.0%	88.9%
G5	*Resolution and notification - 42 CFR 438.408*	100.0%	100.0%	100.0%	85.7%	100.0%
G6	*Expedited resolution of appeals - 42 CFR 438.410*	100.0%	100.0%	100.0%	100.0%	100.0%
G7	*Information about grievance and appeal system to providers and subcontractors - 42 CFR 438.414*	100.0%	100.0%	100.0%	100.0%	100.0%
G8	*Record keeping requirements - 42 CFR 438.416*	100.0%	100.0%	100.0%	100.0%	100.0%
G9	*Continuation of benefits while the local appeal and the state Fair Hearing are pending - 42 CFR 438.420*	100.0%	100.0%	100.0%	100.0%	100.0%
G10	*Effectuation of reversed appeal resolution - 42 CFR 438.424*	100.0%	100.0%	100.0%	100.0%	100.0%
Overall		**95.6%**	**97.7%**	**97.8%**	**95.5%**	**93.3%**

Appendix 4 – Network Adequacy Validation: Member to Provider Ratios by Service Type

FY 23-24 Service Types Meeting Member to Provider Ratios - Statewide					
Program	**Service Type**	**Target Met**	**Target Not Met**	**Total**	**Percent Met**
FC	Adult Day Care	95	14	109	87.2%
FC	Adult Residential Care (1-2 bed)	120	14	134	89.6%
FC	Adult Residential Care (3-4 bed)	121	11	132	91.7%
FC	Adult Residential Care (Community-based)	136	0	136	100.0%
FC	Adult Residential Care - Residential Care Apartment Complex	110	7	117	94.0%
FC	Alcohol and Other Drug Abuse Day Treatment	50	6	56	89.3%
FC	Alcohol and Other Drug Abuse Services	132	10	142	93.0%
FC	Community Support Program	86	26	112	76.8%
FC	Consumer-Directed Supports (Self-Directed Supports) Broker	81	4	85	95.3%
FC	Counseling and Therapeutic Resources	140	1	141	99.3%
FC	Daily Living Skills Training	123	1	124	99.2%
FC	Day Habilitation Services	150	5	155	96.8%
FC	Financial Management Services	142	0	142	100.0%
FC	Home Delivered Meals	142	0	142	100.0%
FC	Home Health Services	139	2	141	98.6%
FC	Mental Health Day Treatment	40	24	64	62.5%
FC	Mental Health Services	142	0	142	100.0%
FC	Nursing (Including Intermittent and Private Duty)	101	0	101	100.0%
FC	Nursing Home Stays	142	0	142	100.0%
FC	Occupational Therapy	108	12	120	90.0%
FC	Personal Care	103	0	103	100.0%
FC	Physical Therapy	130	2	132	98.5%
FC	Prevocational Services	105	15	120	87.5%
FC	Respiratory Care	36	1	37	97.3%
FC	Respite Care	140	0	140	100.0%
FC	Self-Directed Supports	132	2	134	98.5%
FC	Skilled Nursing Services	19	2	21	90.5%
FC	Speech and Language Pathology Services	111	12	123	90.2%
FC	Supported Employment - Individual	117	5	122	95.9%
FC	Supported Employment - Non-Specified	14	1	15	93.3%
FC	Supported Employment - Small Group	100	24	124	80.7%
FC	Supportive Home Care	184	3	187	98.4%

FY 23-24 Service Types Meeting Member to Provider Ratios - Statewide					
Program	**Service Type**	**Target Met**	**Target Not Met**	**Total**	**Percent Met**
FC	Transportation (Excluding Ambulance)	89	8	97	91.8%
FC	Transportation (Specialized) - Community	68	0	68	100.0%
FC	Transportation (Specialized) - Other	45	5	50	90.0%
FC	Transportation - Non-Specified	15	0	15	100.0%
FC	**Total**	**3708**	**217**	**3925**	**94.5%**
FCP	Adult Day Care	22	0	22	100.0%
FCP	Adult Residential Care (1-2 bed)	21	0	21	100.0%
FCP	Adult Residential Care (3-4 bed)	22	0	22	100.0%
FCP	Adult Residential Care (Community-based)	22	0	22	100.0%
FCP	Adult Residential Care - Residential Care Apartment Complex	19	2	21	90.5%
FCP	Alcohol and Other Drug Abuse Day Treatment	21	1	22	95.5%
FCP	Alcohol and Other Drug Abuse Services	22	0	22	100.0%
FCP	Community Support Program	22	0	22	100.0%
FCP	Consumer-Directed Supports (Self-Directed Supports) Broker	13	0	13	100.0%
FCP	Counseling and Therapeutic Resources	20	1	21	95.2%
FCP	Daily Living Skills Training	13	0	13	100.0%
FCP	Day Habilitation Services	31	0	31	100.0%
FCP	Financial Management Services	22	0	22	100.0%
FCP	Home Delivered Meals	22	0	22	100.0%
FCP	Home Health Services	22	0	22	100.0%
FCP	Mental Health Day Treatment	20	1	21	95.2%
FCP	Mental Health Services	22	0	22	100.0%
FCP	Nursing (Including Intermittent and Private Duty)	13	0	13	100.0%
FCP	Nursing Home Stays	22	0	22	100.0%
FCP	Occupational Therapy	22	0	22	100.0%
FCP	Personal Care	14	0	14	100.0%
FCP	Physical Therapy	22	0	22	100.0%
FCP	Prevocational Services	21	1	22	95.5%
FCP	Respiratory Care	13	0	13	100.0%
FCP	Respite Care	22	0	22	100.0%
FCP	Self-Directed Supports	31	0	31	100.0%
FCP	Skilled Nursing Services	14	0	14	100.0%
FCP	Speech and Language Pathology Services	22	0	22	100.0%
FCP	Supported Employment - Individual	13	0	13	100.0%
FCP	Supported Employment - Non-Specified	9	0	9	100.0%
FCP	Supported Employment - Small Group	12	1	13	92.3%

FY 23-24 Service Types Meeting Member to Provider Ratios - Statewide					
Program	**Service Type**	**Target Met**	**Target Not Met**	**Total**	**Percent Met**
FCP	Supportive Home Care	49	0	49	100.0%
FCP	Transportation (Excluding Ambulance)	10	3	13	76.9%
FCP	Transportation (Specialized) - Other	7	1	8	87.5%
FCP	Transportation - Non-Specified	9	0	9	100.0%
FCP	**Total**	**681**	**11**	**692**	**98.4%**
PACE	Adult Day Care	4	0	4	100.0%
PACE	Adult Residential Care (1-2 bed)	4	0	4	100.0%
PACE	Adult Residential Care (3-4 bed)	4	0	4	100.0%
PACE	Adult Residential Care (Community-based)	4	0	4	100.0%
PACE	Adult Residential Care - Residential Care Apartment Complex	4	0	4	100.0%
PACE	Alcohol and Other Drug Abuse Day Treatment	4	0	4	100.0%
PACE	Alcohol and Other Drug Abuse Services	4	0	4	100.0%
PACE	Community Support Program	4	0	4	100.0%
PACE	Counseling and Therapeutic Resources	4	0	4	100.0%
PACE	Day habilitation services	8	0	8	100.0%
PACE	Financial Management Services	4	0	4	100.0%
PACE	Home Delivered Meals	4	0	4	100.0%
PACE	Home Health Services	4	0	4	100.0%
PACE	Mental Health Day Treatment	3	1	4	75.0%
PACE	Mental Health Services	4	0	4	100.0%
PACE	Nursing Home Stays	4	0	4	100.0%
PACE	Occupational Therapy	4	0	4	100.0%
PACE	Personal Care	4	0	4	100.0%
PACE	Physical Therapy	4	0	4	100.0%
PACE	Prevocational Services	4	0	4	100.0%
PACE	Respite Care	4	0	4	100.0%
PACE	Self-Directed Supports	8	0	8	100.0%
PACE	Skilled Nursing Services	4	0	4	100.0%
PACE	Speech and Language Pathology Services	4	0	4	100.0%
PACE	Supported Employment - Non-Specified	4	0	4	100.0%
PACE	Supportive Home Care	16	0	16	100.0%
PACE	Transportation - Non-Specified	4	0	4	100.0%
PACE	**Total**	**127**	**1**	**128**	**99.2%**

Appendix 5 – Network Adequacy Validation: Provider Directory Results

FY 23 – 24 Provider Directory Match Results - Statewide					
Program	**Service Type**	**Location Match**	**Location Not Match**	**Total**	**Percent Match**
FC	Adult Day Care	70	9	79	88.6%
FC	Adult Residential Care (1-2 bed)	461	76	537	85.9%
FC	Adult Residential Care (3-4 bed)	1037	93	1130	91.8%
FC	Adult Residential Care (Community-based)	962	54	1016	94.7%
FC	Adult Residential Care - Residential Care Apartment Complex	174	5	179	97.2%
FC	Alcohol and Other Drug Abuse Day Treatment	111	5	116	95.7%
FC	Alcohol and Other Drug Abuse Services	378	33	411	92.0%
FC	Community Support Program	112	9	121	92.6%
FC	Consumer-Directed Supports (Self-Directed Supports) Broker	11	0	11	100.0%
FC	Counseling and Therapeutic Resources	249	21	270	92.2%
FC	Daily Living Skills Training	115	9	124	92.7%
FC	Day Habilitation Services	181	14	195	92.8%
FC	Financial Management Services	79	12	91	86.8%
FC	Home Delivered Meals	88	8	96	91.7%
FC	Home Health Services	221	17	238	92.9%
FC	Mental Health Day Treatment	101	5	106	95.3%
FC	Mental Health Services	834	73	907	92.0%
FC	Nursing (Including Intermittent and Private Duty)	109	16	125	87.2%
FC	Nursing Home Stays	570	41	611	93.3%
FC	Occupational Therapy	877	53	930	94.3%
FC	Other	2521	249	2770	91.0%
FC	Personal Care	187	3	190	98.4%
FC	Physical Therapy	1019	65	1084	94.0%
FC	Prevocational Services	88	8	96	91.7%
FC	Respiratory Care	50	3	53	94.3%
FC	Respite Care	1791	81	1872	95.7%
FC	Self-Directed Supports	99	12	111	89.2%
FC	Skilled Nursing Services	15	2	17	88.2%
FC	Speech and Language Pathology Services	745	43	788	94.5%
FC	Supported Employment - Individual	77	7	84	91.7%
FC	Supported Employment - Non-Specified	55	0	55	100.0%
FC	Supported Employment - Small Group	29	5	34	85.3%
FC	Supportive Home Care	952	81	1033	92.2%

FY 23 – 24 Provider Directory Match Results - Statewide					
Program	**Service Type**	**Location Match**	**Location Not Match**	**Total**	**Percent Match**
FC	Transportation (Excluding Ambulance)	32	8	40	80.0%
FC	Transportation (Specialized) - Community	38	7	45	84.4%
FC	Transportation (Specialized) - Other	177	30	207	85.5%
FC	Transportation - Non-Specified	187	1	188	99.5%
FC	**Total**	**14802**	**1158**	**15960**	**92.7%**
FCP	Adult Day Care	39	0	39	100.0%
FCP	Adult Residential Care (1-2 bed)	130	2	132	98.5%
FCP	Adult Residential Care (3-4 bed)	628	6	634	99.1%
FCP	Adult Residential Care (Community-based)	405	4	409	99.0%
FCP	Adult Residential Care - Residential Care Apartment Complex	81	0	81	100.0%
FCP	Alcohol and Other Drug Abuse Day Treatment	66	2	68	97.1%
FCP	Alcohol and Other Drug Abuse Services	113	4	117	96.6%
FCP	Community Support Program	29	0	29	100.0%
FCP	Consumer-Directed Supports (Self-Directed Supports) Broker	4	0	4	100.0%
FCP	Counseling and Therapeutic Resources	82	5	87	94.3%
FCP	Daily Living Skills Training	23	2	25	92.0%
FCP	Day Habilitation Services	108	4	112	96.4%
FCP	Financial Management Services	33	1	34	97.1%
FCP	Home Delivered Meals	30	0	30	100.0%
FCP	Home Health Services	102	2	104	98.1%
FCP	Mental Health Day Treatment	48	1	49	98.0%
FCP	Mental Health Services	303	11	314	96.5%
FCP	Nursing (Including Intermittent and Private Duty)	34	5	39	87.2%
FCP	Nursing Home Stays	134	9	143	93.7%
FCP	Occupational Therapy	417	20	437	95.4%
FCP	Other	788	56	844	93.4%
FCP	Personal Care	115	1	116	99.1%
FCP	Physical Therapy	479	24	503	95.2%
FCP	Prevocational Services	34	2	36	94.4%
FCP	Respiratory Care	30	3	33	90.9%
FCP	Respite Care	1077	12	1089	98.9%
FCP	Self-Directed Supports	65	8	73	89.0%
FCP	Skilled Nursing Services	14	0	14	100.0%
FCP	Speech and Language Pathology Services	338	15	353	95.8%
FCP	Supported Employment - Individual	16	2	18	88.9%
FCP	Supported Employment - Non-Specified	38	0	38	100.0%

FY 23 – 24 Provider Directory Match Results - Statewide					
Program	**Service Type**	**Location Match**	**Location Not Match**	**Total**	**Percent Match**
FCP	Supported Employment - Small Group	10	2	12	83.3%
FCP	Supportive Home Care	578	19	597	96.8%
FCP	Transportation (Excluding Ambulance)	4	1	5	80.0%
FCP	Transportation (Specialized) - Other	4	1	5	80.0%
FCP	Transportation - Non-Specified	165	1	166	99.4%
FCP	**Total**	**6564**	**225**	**6789**	**96.7%**
PACE	Adult Day Care	33	0	33	100.0%
PACE	Adult Residential Care (1-2 bed)	101	1	102	99.0%
PACE	Adult Residential Care (3-4 bed)	524	0	524	100.0%
PACE	Adult Residential Care (Community-based)	278	0	278	100.0%
PACE	Adult Residential Care - Residential Care Apartment Complex	54	0	54	100.0%
PACE	Alcohol and Other Drug Abuse Day Treatment	21	0	21	100.0%
PACE	Alcohol and Other Drug Abuse Services	19	0	19	100.0%
PACE	Community Support Program	5	0	5	100.0%
PACE	Counseling and Therapeutic Resources	14	0	14	100.0%
PACE	Day habilitation services	66	1	67	98.5%
PACE	Financial Management Services	18	0	18	100.0%
PACE	Home Delivered Meals	11	0	11	100.0%
PACE	Home Health Services	39	0	39	100.0%
PACE	Mental Health Day Treatment	6	0	6	100.0%
PACE	Mental Health Services	90	1	91	98.9%
PACE	Nursing Home Stays	56	0	56	100.0%
PACE	Occupational Therapy	206	0	206	100.0%
PACE	Other	278	0	278	100.0%
PACE	Personal Care	101	1	102	99.0%
PACE	Physical Therapy	221	1	222	99.6%
PACE	Prevocational Services	18	0	18	100.0%
PACE	Respite Care	834	2	836	99.8%
PACE	Self-Directed Supports	2	0	2	100.0%
PACE	Skilled Nursing Services	13	0	13	100.0%
PACE	Speech and Language Pathology Services	165	0	165	100.0%
PACE	Supported Employment - Non-Specified	26	0	26	100.0%
PACE	Supportive Home Care	418	4	422	99.1%
PACE	Transportation - Non-Specified	118	0	118	100.0%
PACE	**Total**	**3735**	**11**	**3746**	**99.7%**

Appendix 6 – Care Management Review: FY 2023 – 2024 MCO Comparative Scores

Family Care Program

Indicator #	Indicator Description	Managed Care Programs FY 23-24			
		CCI	Inclusa	LCI	MCW
	Records Reviewed	**266**	**267**	**260**	**264**
1A	Comprehensive Assessment	78.2%	40.4%	92.7%	92.8%
1B	Timely Assessment	97.0%	97.8%	99.2%	92.4%
2A	Comprehensive MCP	64.7%	53.6%	68.8%	81.4%
2B	Timely MCP	77.8%	79.4%	90.0%	83.3%
2C	MCP Signed Annually	95.1%	97.8%	96.2%	95.5%
2D	Change in Condition	89.3%	87.4%	87.9%	94.7%
2E	Service Authorizations	94.4%	87.6%	93.1%	92.4%
2F	Essential Providers	75.7%	75.7%	92.7%	88.1%
3A	Timely Coordination	94.0%	95.5%	95.8%	95.1%
3B	Timely Follow-Up	70.7%	62.5%	66.9%	56.1%
3C	Member Rights	94.4%	98.9%	96.9%	95.1%
3D	IDT Contact	92.5%	85.4%	95.4%	84.5%
4A	LTCFS Consistency	67.1%	44.6%	53.2%	62.1%
4B	Rescreen	47.4%	22.2%	29.4%	47.1%
5A	Needs Addressed	99.2%	100.0%	100.0%	99.2%
Overall		**85.0%**	**78.8%**	**88.0%**	**86.6%**

Family Care Partnership Program

Indicator #	Indicator Description	Managed Care Programs FY 23-24		
		CCI	*i*Care*	MCW
	Records Reviewed	**197**	**N/A**	**222**
1A	Comprehensive Assessment	81.7%	N/A	89.2%
1B	Timely Assessment	98.0%	N/A	95.5%
2A	Comprehensive MCP	77.7%	N/A	90.1%
2B	Timely MCP	79.7%	N/A	84.2%
2C	MCP Signed Annually	94.9%	N/A	94.6%
2D	Change in Condition	91.4%	N/A	92.0%
2E	Service Authorizations	94.4%	N/A	89.2%
2F	Essential Providers	90.7%	N/A	83.9%

Indicator #	Indicator Description	Managed Care Programs FY 23-24		
		CCI	*i*Care*	MCW
3A	Timely Coordination	92.4%	N/A	91.9%
3B	Timely Follow-Up	70.6%	N/A	58.6%
3C	Member Rights	93.4%	N/A	94.1%
3D	IDT Contact	95.4%	N/A	83.8%
4A	LTCFS Consistency	69.7%	N/A	39.2%
4B	Rescreen	25.8%	N/A	30.4%
5A	Needs Addressed	100.0%	N/A	99.1%
Overall		**87.3%**	**N/A**	**84.8%**

**No review was conducted for iCare FCP due to acquisition.*

Program of All-Inclusive Care for the Elderly

Indicator #	Indicator Description	Managed Care Program FY 23-24
		CCI
	Records Reviewed	**175**
1A	Comprehensive Assessment	90.9%
1B	Timely Assessment	94.9%
2A	Comprehensive MCP	96.0%
2B	Timely MCP	89.7%
2C	MCP Signed Annually	99.4%
2D	Change in Condition	96.2%
2E	Service Authorizations	96.6%
2F	Essential Providers	92.8%
3A	Timely Coordination	97.7%
3B	Timely Follow-Up	81.7%
3C	Member Rights	99.4%
3D	IDT Contact	96.6%
4A	LTCFS Consistency	59.3%
4B	Rescreen	63.0%
5A	Needs Addressed	99.4%
Overall		**92.5%**