MetaStar

External Quality Review

Fiscal Year 2024 – 2025

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Annual Technical Report

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

In partnership with

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Final Report: January 27, 2026

MetaStar, Inc. – Wisconsin's External Quality Review Organization

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

MetaStar conducts EQRs for organizations managing Wisconsin's BadgerCare Plus, Supplemental Security Income, Foster Care Medical Home, and Children with Medical Complexity programs. Additionally, MetaStar reviews Medicaid managed long-term care programs, including Family Care, Family Care Partnership, and the Program of All-Inclusive Care for the Elderly (PACE), as well as Home and Community-Based Services (HCBS) Waiver programs for adults and children with disabilities. MetaStar also provides services to both state and private clients. For more information, visit www.metastar.com.

Myers and Stauffer

MetaStar partners with Myers and Stauffer, a nationally recognized certified public accounting and consulting firm, to conduct network adequacy validation. Specializing in Medicaid rate development, quality improvement consulting, auditing, data analysis, and data management, Myers and Stauffer works with states across the country. For more information, visit Government-Sponsored Health and Human Services Auditing and Consulting | Myers and Stauffer.

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Acronyms Used in Report

Acronym	Description
AHRQ	Agency for Healthcare Research and Quality
ADL	Activity of Daily Living
AODA	Alcohol & Other Drug Abuse
APOA-HC	Activated Power of Attorney – Health Care
BC+	BadgerCare Plus
CCI	Community Care, Inc.
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CM	Care Manager
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CSP	Community Support Program
CY	Calendar Year
DHA	Division of Hearings and Appeals
DHS	Wisconsin Department of Health Services
DME	Durable Medical Equipment
DMS	Disposable Medical Supplies
ED	Emergency Department
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Family Care
FCP	Family Care Partnership
FY	Fiscal Year
GT	Gainwell Technologies
HCBS	Home and Community Based Services
HEDIS®	Healthcare Effectiveness Data and Information Set
HRS	Health Related Services
IADL	Instrumental Activity of Daily Living
*i*Care	Independent Care Health Plan
IDT	Interdisciplinary team
IMA	Immunizations for Adolescents
IS	Information System
ISCA	Information System Capabilities Assessment
ISP	Individual Service Plan
LCI	Lakeland Care, Inc.
LEIE	Lists of Excluded Individuals and Entities

Acronym	Description
LTCFS	Long Term Care Functional Screen
LTSS	Long-Term Services and Supports
MA	Medicaid
MAC	Member Advisory Committee
MCW	My Choice Wisconsin
MCO	Managed Care Organization
MCP	Member-Centered Plan
MOU	Memorandum of Understanding
MY	Measurement Year
N/A	Not Applicable
NAV	Network Adequacy Validation
NC	Not Comparable
NCQA	National Committee for Quality Assurance
NS	No Significant Change
OIG	Office of Inspector General
OT	Occupational Therapy
PACE	Program of All-Inclusive Care for the Elderly
PDSA	Plan-Do-Study-Act
PERS	Personal Emergency Response System
PCV	Pneumococcal Conjugate Vaccine
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PMV	Performance Measure Validation
PT	Physical Therapy
QAPI	Quality Assessment and Performance Improvement
RN	Registered Nurse
RNCM	Registered Nurse Care Manager
SDS	Self-Directed Supports
SHC	Supportive Home Care
SOD	Statement of Deficiency
SSI	Supplemental Security Income
ST	Speech Therapy
URAC	Utilization Review Accreditation Commission

Executive Summary

Purpose and Overview of Report

The CFR at 42 CFR § 438 requires states that operate MCOs and PIHPs to provide for EQR of these organizations. Under 42 CFR § 438.364, states are required to contract with a qualified EQRO to summarize findings from each EQR activity, where data is aggregated and analyzed. Conclusions are then drawn regarding the quality, timeliness, and access to health care provided by the organizations to Medicaid beneficiaries.

EQR activities are the mandatory and optional activities, as set forth in 42 CFR § 438.358, and are intended to:

- Improve states' ability to oversee and manage the organizations they contract with for services; and
- Help organizations improve their performance with respect to quality, timeliness, and access to care.

To meet its obligations, DHS contracts with MetaStar to plan and conduct review activities according to the CMS EQR Protocols. MetaStar conducts EQR for all MCOs operating FC, FCP, PACE, BC+, and SSI or SSI-related Medicaid programs in the State of Wisconsin. An additional MCO also provides comprehensive and coordinated health services for children and youth enrolled in the PIHP for the foster care medical home benefit.

This report summarizes the findings from the FY 2024-2025 EQR activities listed below, including data aggregation and analysis.

- Validation of Performance Improvement Projects
- Validation of Performance Measures
- Review of Compliance with Medicaid and CHIP Managed Care Regulations
- Validation of Network Adequacy
- Care Management Review
- Information Systems Capabilities Assessment

Wisconsin Medicaid Overview

Since the 1990s, DHS has delivered long-term care services to older adults and individuals with developmental and physical disabilities through a managed care model**.** In 1990, Wisconsin implemented PACE, a national Medicare-Medicaid initiative designed to provide

comprehensive medical, long-term care, and prescription drug coverage to adults aged 55 and older who meet nursing home level-of-care criteria.

In 1995, Wisconsin began redesigning its long-term care system by introducing the FCP, which integrates Medicaid long-term care services and supports with Medicare acute and primary care benefits through Medicare Advantage Special Needs Plans. This program serves individuals who are dually eligible for Medicare and Medicaid and require an institutional level of care.

In 1998, Wisconsin launched FC as a pilot program in five counties. Family Care provides all Medicaid-covered long-term care services and supports to eligible individuals who qualify for, or are at risk of, institutional care. Since its inception, Family Care has expanded statewide and now operates in all 72 Wisconsin counties as a fully entitled program.

Together, PACE, Partnership, and Family Care represent Wisconsin's commitment to delivering managed long-term services and supports that promote access, member choice, and health equity for older adults and individuals with disabilities.

State Quality Strategy Evaluation

The Wisconsin Medicaid Managed Care Quality Strategy outlines DHS' goals, objectives, and mechanisms for improving managed care services for Medicaid beneficiaries. This Annual Technical Report evaluates how EQR activities support and align with the Quality Strategy, particularly for FC, FCP, and PACE.

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, quality of Assisted Living Communities; and reducing potentially preventable hospital readmissions.
- Delivery System and Person-Centered Care - Delivery system strategies focus on the way organizations care for members. These strategies emphasize care management and coordination, use of health homes and medical homes for specific conditions and populations, and continual attention to the health and safety of Medicaid members. Person-centered care strategies focus on building partnerships between members and

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

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 plays a critical role in supporting member outcomes and is expected to contribute to the goals outlined in the state's Quality Strategy. External quality review activities conducted by MetaStar promote accountability by evaluating whether programs operate within the framework of the Quality Strategy. These reviews provide DHS with insight into each organization's infrastructure and consistency in supporting quality improvement.

As required by 42 CFR § 438.340, the Quality Strategy serves as the foundation for evaluating MCOs. EQR activities, including PIP validation, performance measure reviews, and compliance assessments, ensure that MCOs meet federal standards and contribute to continuous quality improvement.

During the 2023–2024 review period, DHS advanced its Quality Strategy through:

- PIPs targeting fall prevention, medication management, and member satisfaction.
- EQR findings that informed oversight enhancements and technical assistance to MCOs.
- Member-centered initiatives promoting independence, safety, and community inclusion.

EQR activities assess the extent to which policies, processes, and procedures align with state standards for compliance and quality. They also evaluate the organization's adherence to its DHS contract and its capacity to safeguard members' health and welfare while supporting care management teams in delivering cost-effective, outcome-driven services.

DHS used EQR results to:

- Require corrective action plans for care coordination deficiencies.
- Deliver targeted training on root cause analysis and PIP methodology.
- Ensure transparency by publishing this Annual Technical Report and maintaining a five-year archive online.

As required by CMS, the state must submit its Quality Strategy and review and update it at least every three years. This review includes an evaluation of the strategy's effectiveness, conducted using CMS's EQR protocols. These protocols identify strengths and effective practices, as well as areas needing improvement.

Evaluation of Quality, Timeliness, and Access

In accordance with CMS guidelines for this annual technical report, the EQRO is required to assess each MCO's strengths and weaknesses in relation to the quality, timeliness, and access to health care services**.** All programs under review provide Home and Community-Based Services for long-term services and supports, while the FCP and PACE programs also deliver acute and primary care services. Compliance with these review activities ensures that MCOs are meeting federal requirements for access, timeliness, and quality across both health care and LTSS domains.

This section of the report presents an analysis of each MCO's performance, highlighting strengths, areas of progress, and recommendations for improvement. The tables below summarize the mandatory review activities, scope of evaluation, and findings related to quality, timeliness, and access for each program operated by the MCOs.

Summary of EQR Activities and Recommendations

EQR federal regulations in 42 CFR Part § 438 specify the mandatory and optional activities that the EQRO must address in a manner consistent with CMS protocols. MetaStar conducted Wisconsin's 2024 EQR activities in alignment with CMS protocols. Recommendations are provided for each EQR activity and included in the respective sections of this report. The section below summarizes assessments of quality, timeliness, and access to health care services conducted through each review activity. Compliance with these activities provides assurance that the State is meeting federal requirements related to access, timeliness, and quality of services, including both health care and LTSS. State-level findings highlight strengths, opportunities for improvement, and recommendations. Additionally, the review activities support various components of the State's 2021 Medicaid Managed Care Quality Strategy, which are also identified in this section.

Quality Strategy Effectiveness

To fulfill the requirement established by federal regulation in 42 CFR 438 Subpart E § 438.340, the Wisconsin Managed Care Quality Strategy created a comprehensive strategy to assess,

monitor, coordinate the quality of the managed care services, and develop measurable goals and targets for continuous quality improvement.

EQR is one part of an interrelated set of quality requirements that apply to Medicaid managed care. Per 42 CFR §§ 438.364(a)(4) and 457.1250, the feedback obtained from the state's EQRO should be used by states when examining and updating the quality strategy.

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.

Table 1. State Quality Strategy Evaluation

State Quality Strategies	Strengths	Recommendations
Enhance Value-Based Purchasing	• MCOs selected and implemented evidence-based interventions likely to lead to desired improvements. • Most PIP results showed significant improvements.	• Ensure PIP variables are adequate to answer the aim statement in all PIPs.
Reduce Avoidable, Non-Value Added Care	• MCOs upheld state standards ensuring medically necessary services were appropriately authorized and delivered.	• Strengthen service authorization practices and ensure timely issuance of *Notices of Adverse Benefit Determinations*.
Enhance Care Coordination and Person-Centered Care	• IDTs conducted comprehensive assessments and coordinated services effectively. • MCPs were updated timely in PACE and FC programs.	• Improve MCP comprehensiveness and follow-up practices. • Ensure MCPs are reviewed every six months and LTCFSs

State Quality Strategies	Strengths	Recommendations
		are updated after changes in condition.
Ensure Health and Safety	• IDT staff actively identified and responded to member risks, upheld member rights, and ensured protection from inappropriate use of personal resources. • Provider networks met or exceeded adequacy standards. • Practices were demonstrated to ensure members receive pneumococcal vaccinations after the age of 65.	• Ensure compliance with essential provider requirements and improve documentation and monitoring of health and safety risks. • Improve provider networks in counties where adequacy standards were not met, especially for mental health day treatment and specialized transportation. • Conduct a root cause analysis to identify reasons for declining influenza vaccination rates.
Promote Member Engagement	• MCOs ensured members received timely, accurate, and accessible information to make informed decisions. • Members were actively involved in care decisions.	• Update policies for electronic materials to ensure timely paper delivery. • Enhance member involvement in MCP development.
Long-Term Care Choice	• Programs demonstrated strong practices in maintaining MCPs and coordinating long-term care services. • All programs showed strengths in meeting wait-time standards for various services.	• Align LTCFS with MCO documentation and ensure timely updates following changes in condition. • Decrease wait-times for services where standards were not met, including adaptive aids, durable medical equipment, and housing counseling.

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 PIP 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 MCO in measurement year 2024.

Table 2: PIP Summary of Findings and Recommendations – State Level

State Level
Strengths
• MCOs conducted and reported detailed research regarding the topic selection and its importance to members. • The projects established clear, concise, measurable, and answerable aim statements. • MCOs clearly identified the PIP population in relation to the aim statements. • All clinical projects selected PIP variables and performance measures that were clear indicators of performance. • MCOs used valid and reliable procedures to collect the PIP data and inform its measurements. • All projects used appropriate techniques to analyze the PIP data and interpret the results. • MCOs selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement. The MCOs detailed the effectiveness of all interventions used for the PIPs. • MCOs utilized methodology that was likely to demonstrate significant and sustained improvement. • Most PIP results demonstrated significant improvements, that are likely attributed to the improvement strategies implemented during the measurement year.
Weaknesses/Opportunities for Improvement
• Two MCOs used variables that did not align with the project aim statements, making the variables inadequate to answer the study question for the non-clinical PIPs.
Recommendations
• Ensure the PIP variables are adequate to answer the aim statement in all PIPs.

Protocol 2: Validation of Performance Measures

Validation of Performance Measures, or Performance Measure Validation, 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 MCOs 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 2024. Technical definitions for each measure were provided by DHS.

Table 3: PMV Summary of Findings and Recommendations – State Level

State Level
Strengths
• The FCP and PACE programs demonstrated practices to ensure members receive pneumococcal vaccinations after the age of 65.
Weaknesses/Opportunities for Improvement
• Influenza rates have declined for five consecutive years, with Family Care experiencing a statistically significant decline in the prior three measurement years when compared to vaccination rates from the prior year. • Although the FC program results for the pneumococcal vaccination improved slightly from the previous measurement year, the rate remains below 90 percent, indicating opportunities for improvement.
Recommendations
• Conduct a root cause analysis to identify the reason for declining influenza vaccination rates for all programs. • Continue efforts to increase influenza and pneumococcal vaccination rates by monitoring MCO efforts to educate members on the benefits of the vaccination.

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

Review of Compliance with Medicaid and CHIP Managed Care Regulations, or Compliance with Standards, is a mandatory activity, identified in 42 CFR § 438.358, and is conducted according to federal protocol standards. The review assesses the organization's level of compliance with federal and state regulations.

The compliance standards are organized into three main categories:

- MCO Standards
- QAPI Standards
- Grievance Systems Standards

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

This report is year one of the cycle and includes the evaluation of the MCO Standards. This report evaluated compliance requirements from FY 24-25.

Table 4: Compliance with Standards - Summary of Findings and Recommendations – State Level

State Level
Strengths
• The MCOs ensured that all services covered under the state plan were available and accessible to members in a timely manner. • The MCOs maintained provider networks that deliver timely access to services. • The MCOs ensured culturally competent service delivery and promoted inclusive care by addressing the needs of enrollees with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and individuals of all sexes, gender identities, and sexual orientations. • The MCOs implemented procedures that ensured coordinated, continuous care for all members, including those with special health care needs. • The MCOs implemented procedures that supported comprehensive coordination and continuity of care for members. • The organizations ensured disenrollment processes were fair, transparent, and consistent with federal guidelines. • The MCOs consistently upheld state standards by ensuring that all covered services were medically necessary, appropriately authorized, and delivered in accordance with federal requirements. • The MCOs ensured that all members received timely, accurate, and accessible information necessary to make informed decisions about their care. • The MCOs ensured that members consistently received clear, accurate, and accessible information about available provider options. Information was presented in a manner appropriate to each member's condition and ability to understand, enabling informed decision-making. • The MCOs ensured that members were actively involved in decisions regarding their care and were protected from any form of restraint or seclusion used for coercion, discipline, convenience, or retaliation. • The MCOs ensured that all contracted entities adhered to applicable federal and state laws protecting enrollee rights. • The MCOs maintained ultimate responsibility for all delegated activities and subcontractual relationships. Contracts with subcontractors clearly specified delegated functions, reporting obligations, and remedies for non-performance. • The MCOs adopted and implemented clinical practice guidelines that were evidence-based, responsive to member needs, and developed in consultation with network providers.
Weaknesses/Opportunities for Improvement
• Two MCOs did not maintain complete and current provider directory information on their websites. • MCOs did not consistently ensure follow-up of long-term care services with health care services received by the member, as well as other services available from natural and community supports.

State Level
• Internal monitoring results related to the comprehensiveness of MCPs indicated a need for improvement in the FC and FCP programs for two MCOs. • Internal monitoring results related to the timely completion and signing of MCPs indicated a need for improvement for two MCOs, as did MetaStar's CMR findings. • Two MCOs did not meet requirements for providing electronic materials in paper form without charge and within five business days. • MCOs did not implement written policies and procedures for a network selection and retention process related to continuity of care for newly enrolled members.
Recommendations
• Revise provider directory policies to clearly define circumstances under which a provider may be excluded from the directory and establish specific timeframes for updating directory information when new providers are added. • Strengthen coordination efforts between long-term care and health care services by improving follow-up practices in the FC and FCP programs. Continued monitoring and feedback mechanisms should be maintained to support consistent quality improvement across all organizations. • Enhance the development of MCPs by ensuring they are fully informed by comprehensive assessments and reflect meaningful involvement of the member and relevant parties. Focused training and oversight may support improved compliance with this requirement. • Prioritize timely completion and signing of initial MCPs within 60 days of enrollment. Continued monitoring and targeted process improvements are recommended to ensure compliance with this requirement. • Update policy documents to include procedures for obtaining member consent to receive electronic materials and ensure the required five-day timeframe for providing paper copies is clearly stated. Staff training should reinforce these requirements to support consistent implementation. • Revise policies to address contract backdating procedures when needed for continuity of care and ensure provider licensure or certification is verified prior to contract finalization. Strengthening oversight and documentation practices will support compliance with network selection and retention requirements.

Protocol 4: Validation of Network Adequacy

Validation of Network Adequacy, or Network Adequacy Validation, is a mandatory activity, identified in 42 CFR § 438.68. The review assesses the capabilities of each organization's provider network to ensure they are sufficient to provide timely and accessible care to Medicaid and 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.

For this mandatory EQR activity, Myers and Stauffer, under contract with MetaStar, collaborated with MetaStar to complete the validation. This report evaluated network adequacy standards from CY 2024.

Table 5: NAV - Summary of Findings and Recommendations – State Level

State Level
Strengths
• All MCO data was submitted accurately, reflects the number of providers available to serve enrolled members, and the ratios meet or exceed established standards. • The MCOs have sufficient numbers of providers relative to their member populations, and the provider networks are adequately distributed to meet member needs. • FC demonstrated strong practices in meeting wait-time standards for home modifications, housing counseling, relocation services, and training services for unpaid caregivers. • Strengths were noted for FCP related to disposable medical supplies, vocational futures planning and support, consumer education and training, relocation services, and training services for unpaid caregivers. • PACE demonstrated strengths with wait-time standards for adaptive aids, assistive technology and communication aids, specialized medical equipment and supplies, disposable medical supplies, personal emergency response system services, home modifications, and relocation services.
Weaknesses/Opportunities for Improvement
• The service types of mental health day treatment, transportation (specialized transportation) – other, and community support program did not meet the network adequacy standards in several counties for FC. • FC MCOs did not consistently meet wait-time standards for adaptive aids, assistive technology and communication aids, durable medical equipment, disposable medical supplies, personal emergency response system services, and vocational futures planning and support. • The FCP program had opportunities for improvement related to adaptive aids, assistive technology and communication aids, specialized medical equipment and supplies, durable medical equipment, personal emergency response system services, home modifications, and housing counseling. • PACE did not consistently meet wait-time standards for durable medical equipment.
Recommendations
• Improve the network of providers in the service types that did not meet the member to provider ratio standard in all counties. • Decrease wait-times for those provider types that did not meet the wait-time standards.

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

Care management review is an optional review activity that assesses key areas of care management practice related to assurances found in the 1915(b) and 1915(c) HCBS Waivers,

and helps determine an organization's level of compliance with its contract with DHS. This report evaluated care management practices from FY 24-25.

Table 6: CMR - Summary of Findings and Recommendations – State Level

State Level
Strengths
• All programs demonstrated strong and effective practices in conducting comprehensive member assessments through their IDTs. These teams consistently explored and documented a wide range of member-specific information, including personal experience outcomes, long-term care goals, individual strengths and preferences, natural and community supports, health and safety risks, and ongoing clinical or functional conditions requiring long-term care, treatment, or regular monitoring. • The PACE program demonstrated strong compliance with DHS-MCO contract requirements through timely development and updates of MCPs and service authorizations. Authorized services align with comprehensive assessments and effectively support members' health, safety, and long-term care outcomes. Documentation shows timely decision-making on service requests and identified needs, and IDT staff consistently assess and respond to member-specific risks, reinforcing a person-centered and proactive approach to care. • The FC and FCP programs showed strengths in maintaining MCPs through timely annual reviews and updates following changes in condition, reinforcing their commitment to person-centered care and responsiveness. • All programs demonstrated strong practices in care coordination through the IDT. Records showed that IDT staff coordinated services and supports in a timely manner and upheld member rights throughout service delivery. Additionally, FC and PACE maintained regular contact with members to monitor ongoing needs. These practices reflect a consistent commitment to person-centered care and continuity of services. • All programs demonstrated strong practices in addressing member health, safety, and welfare. Records showed that IDT staff actively identified and responded to member risks, upheld member rights, and ensured members were not using personal resources for covered services without appropriate counseling. These practices reflect a strong commitment to member protection and contract compliance.
Weaknesses/Opportunities for Improvement
• In the FC and FCP programs, MCPs were not consistently comprehensive. In multiple instances, members had assessed needs, particularly related to ADLs, without corresponding supports documented in the MCP. Additionally, supports for mental/behavioral health and wellness needs were frequently missing. • MCPs were not consistently reviewed or signed every six months as required in the FC and FCP programs. • In the FC and FCP programs, service authorizations were not consistently handled in accordance with DHS-MCO contract requirements.

State Level
• Across the FC, FCP, and PACE programs, there were instances of non-compliance with essential provider requirements, particularly related to SHC providers. • Across the FC, FCP, and PACE programs, IDT staff did not consistently follow up with members in a timely manner to confirm that services and supports were received and effective. This issue was frequently related to lack of follow-up on medical appointments, service provider engagement, and DME needs, such as wheelchair repairs. • The FCP program did not consistently meet minimum contact requirements with members, particularly missing required monthly collateral contacts. • None of the programs demonstrated compliance with requirements for aligning the LTCFS with MCO documentation. • LTCFS updates were frequently missing following changes in member condition, resulting in inaccurate functional eligibility documentation and potential gaps in care planning.
Recommendations
• Ensure MCPs consistently reflect all assessed needs by strengthening IDT practices for linking ADL, mental/behavioral health, and wellness needs to appropriate supports and services during care planning and updates. • Ensure MCPs are reviewed and signed at least every six months by implementing tracking systems and regular IDT audits to support timely updates and compliance with DHS-MCO contract requirements. • Strengthen service authorization practices by ensuring *Notices of Adverse Benefit Determinations* are issued when decisions are not made timely on member requests for new services and when authorized services are reduced, suspended, or terminated, to maintain compliance and protect member rights. • Ensure compliance with essential provider requirements by regularly reviewing and updating documentation for SHC providers, and implementing monitoring processes to verify contract adherence. • Improve follow-up practices by ensuring IDT staff consistently confirm that members received services, such as medical appointments, provider visits, and DME repairs, and assess their effectiveness, using timely documentation and tracking tools. • Ensure FCP staff meet minimum contact requirements by implementing tracking tools and regular oversight to verify timely completion of monthly collateral contacts and maintain compliance with contract standards. • Ensure LTCFS ratings, especially for mobility, toileting, and HRS needs, are accurately reflected in member assessments and MCPs by strengthening documentation practices and updating the LTCFS promptly following changes in condition. • Ensure timely updates to the LTCFS following any change in member condition by implementing clear protocols and regular monitoring to maintain accurate functional eligibility and support effective care planning.

Appendix A: Information Systems Capabilities Assessment

An assessment of a managed care organization's information system is a part of other mandatory review activities, including validation of performance measures, and ensures organizations have the capacity to gather and report data accurately. The DHS contract with managed care organizations requires organizations to maintain a health information system capable of collecting, analyzing, integrating, and reporting data. Each organization receives an information systems capabilities assessment once every three years. This report evaluated IS requirements from FY 24-25.

Table 7: ISCA - Summary of Findings and Recommendations – State Level

State Level
Strengths
• The organization has a strong system, that is maintained and updated by a stable and experienced information system department. • The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes. • The organization's security systems met or exceeded most industry standards, ensuring consistent system and data availability. • The organization's processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter and performance measurement data was provided to DHS.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Overview of Managed Care Organizations and Enrollment

As of July 1, 2025, enrollment was as follows:

Table 8. State Level Enrollment

Program	Enrollment
FC	53,626
FCP	3,245
PACE	508

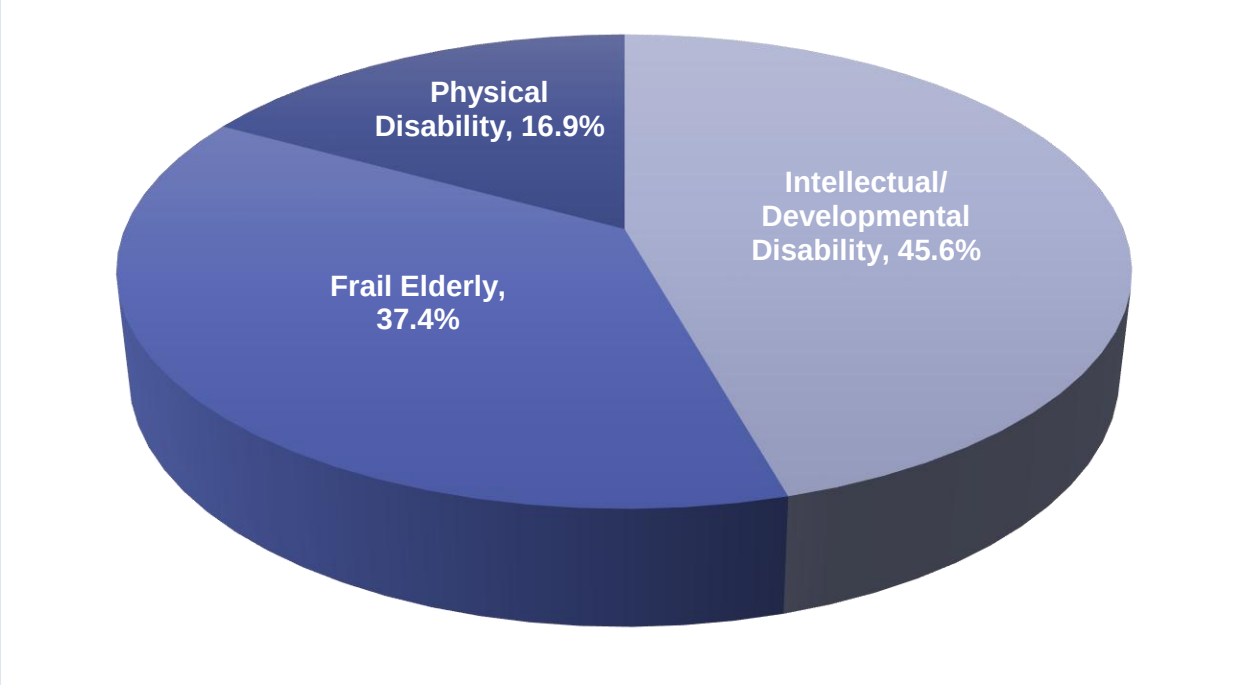
Current enrollment data is available at the following DHS website:

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

Enrollment for all programs was approximately 57,379. This compares to last year's total enrollment of 56,619 as of July 1, 2024.

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.

Chart 1. Total Participants in All Programs by Target Group: July 1, 2025



The table below identifies the programs each organization operates.

Table 9. MCOs, Programs, and Enrollment as of July 1, 2025

Managed Care Organization	Program(s) and Enrollment
Community Care, Inc. (CCI)	FC: 14,177 FCP: 659 PACE: 508
Independent Care Health Plan (*i*Care)	FC: 16,816 FCP: 1,488
Lakeland Care, Inc. (LCI)	FC: 7,352
My Choice Wisconsin (MCW)	FC: 15,281 FCP: 1,098

The following charts compare enrollment for each MCO by program. CCI is the only program that operates PACE.

Chart 2. Family Care Enrollment as of July 1, 2025

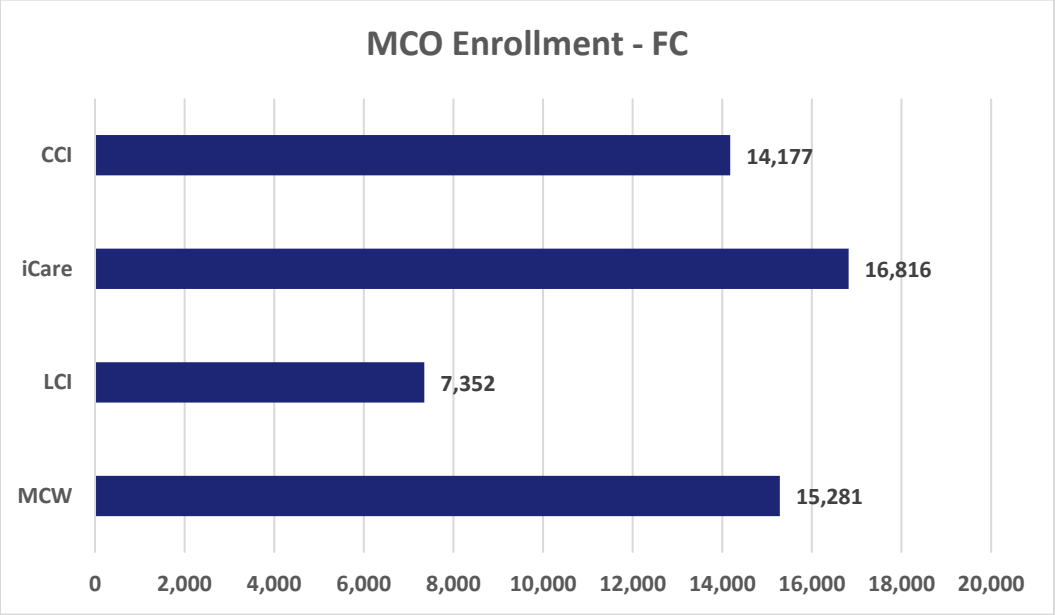
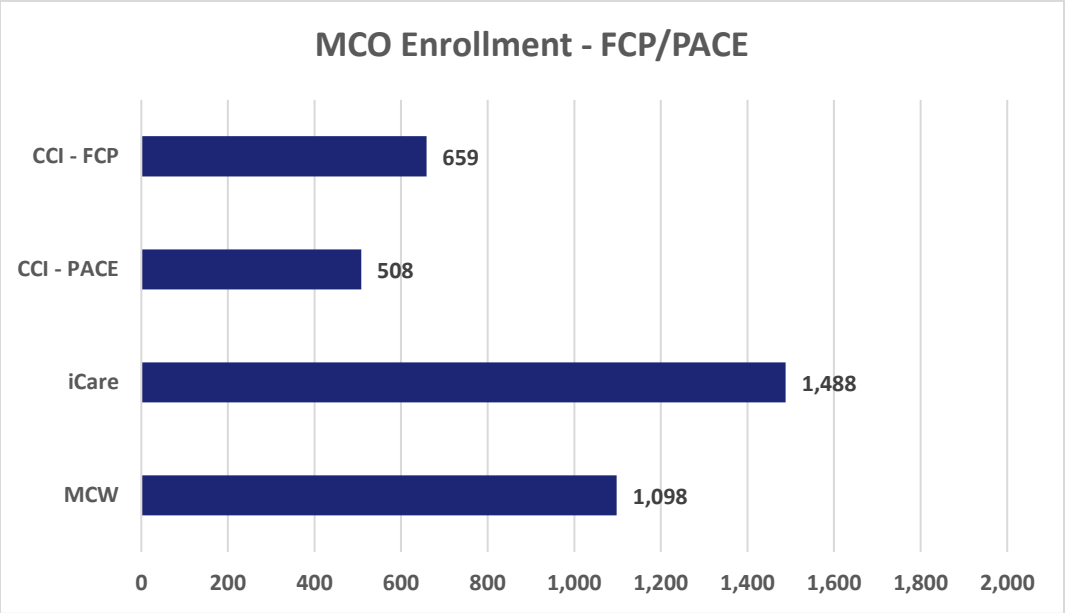


Chart 3. Family Care Partnership Enrollment as of July 1, 2025



Effective January 1, 2025, nine counties in South Central Wisconsin, previously organized into three GSRs, were consolidated into a single region. GSR 12 (Dane County) and GSR 14 (Rock County) have merged into GSR 5. All MCOs now offer FC services in this region, and *i*Care has expanded to include FCP services for members in this area.

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

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

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

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

Protocol 1: Validation of Performance Improvement Projects

The review of MCOs' and PIHPs' PIPs is a mandatory EQR activity identified in 42 CFR § 438.358. Review activities are conducted according to federal protocol. See Appendix 1 for more information about the PIP review methodology.

DHS contractually requires organizations operating FC, FCP, and PACE to annually make active progress on at least one clinical and one non-clinical PIP relevant to long-term care. MCOs operating both FC and FCP may fulfill this PIP requirement by conducting one or both of the required PIPs with both FC and FCP members. If the MCO chooses to combine programs in a single PIP, the baseline and outcome data must be separated by each program.

MCOs and PIHPs must seek DHS approval prior to beginning each project. MetaStar validates clinical and non-clinical PIPs for each organization.

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 was 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.

Validation of Performance Improvement Project - Results

This report addresses the compliance with PIP requirements for the review period of January 1, 2024 – December 31, 2024, with validations conducted in FY 24-25. Compliance with PIP requirements is reported 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.

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. The methodology validation for each PIP includes a table listing each standard that was evaluated for the PIP methodology. The tables indicate the total number of scoring elements and percentage of scoring elements met 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 following rating scale was utilized:

- 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 – The level of confidence that the PIP produced evidence of 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 organization determine baseline and repeat measurements was submitted to MetaStar for the evaluation. The following rating scale was utilized:

- High Confidence = 90.0% - 100.0%
- Moderate Confidence = 80.0% - 89.9%
- Low Confidence = 70.0% - 79.9%
- No Confidence = <70.0%

The validation ratings identified in the table below reflect the EQRO's confidence in the PIP's methods and findings.

Table 10. FY 24-25 PIP Validation Results

MCO	Topic	Clinical/Non-Clinical	Population	Methodology Rating	Significant Improvement Rating
CCI	Diabetic Care	Clinical	Adults	High Confidence	High Confidence
CCI	Member Satisfaction	Non-Clinical	Adults	High Confidence	Low Confidence

MCO	Topic	Clinical/Non-Clinical	Population	Methodology Rating	Significant Improvement Rating
*i*Care	Comprehensive Diabetes Care - FC	Clinical	Adults	High Confidence	High Confidence
*i*Care	Comprehensive Diabetes Care - FCP	Clinical	Adults	High Confidence	High Confidence
*i*Care	Care Management Practices - FC	Non-Clinical	Adults	High Confidence	High Confidence
*i*Care	Caregiver Strain - FCP	Non-Clinical	Adults	High Confidence	High Confidence
LCI	Controlling Blood Pressure	Clinical	Adults	High Confidence	High Confidence
LCI	Advance Care Planning	Non-Clinical	Adults	High Confidence	High Confidence
MCW	Diabetic Care	Clinical	Adults	High Confidence	No Confidence
MCW	Advance Care Planning	Non-Clinical	Adults	High Confidence	Moderate Confidence

The following table displays the EQRO's confidence in the project methodology at the state-level. MetaStar's confidence that the clinical PIPs adhered to acceptable methodology for all phases was high.

Table 11. Clinical PIP Methodology Rating

Standards	Scoring Elements	Percentage	Methodology Rating
Standard 1: PIP Topic	18/18	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	31/32	96.9%	High Confidence

Standards	Scoring Elements	Percentage	Methodology Rating
Standard 6: Data Collection Procedures	39/39	100.0%	High Confidence
Standard 7: Data Analysis and Interpretation of PIP Results	37/38	97.4%	High Confidence
Standard 8: Improvement Strategies	30/30	100.0%	High Confidence
Standard 9: Significant and Sustained Improvement	20/20	100.0%	High Confidence
Methodology Rating	**214/217**	**98.6%**	**High Confidence**

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

The following table displays the EQRO's confidence in the project methodology at the state-level. MetaStar's confidence that the non-clinical PIPs adhered to acceptable methodology for all phases was high.

Table 12. Non-Clinical PIP Methodology Rating

Standards	Scoring Elements	Percentage	Methodology Rating
Standard 1: PIP Topic	15/15	100.0%	High Confidence
Standard 2: PIP Aim Statement	30/30	100.0%	High Confidence
Standard 3: PIP Population	10/10	100.0%	High Confidence
Standard 4: Sampling Method*	N/A	N/A	N/A
Standard 5: PIP Variables and Performance Measures	24/26	92.3%	High Confidence
Standard 6: Data Collection Procedures	38/38	100.0%	High Confidence
Standard 7: Data Analysis and Interpretation of PIP Results	36/36	100.0%	High Confidence
Standard 8: Improvement Strategies	29/30	96.7%	High Confidence
Standard 9: Significant and Sustained Improvement	18/18	100.0%	High Confidence
Methodology Rating	**200/203**	**98.5%**	**High Confidence**

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

Performance Improvement Project - State Level Findings

The following table identifies strengths, weaknesses/opportunities for improvement, and recommendations for clinical PIPs validated in FY 24-25. Strengths are given for standards that scored at or above 90 percent. Weaknesses, or opportunities for improvement, are included for any standard that is below 90 percent, and any scoring element that was not met for more than one organization. Additional opportunities for improvement may be included for elements that are minimally compliant. Recommendations are provided for all identified weaknesses and opportunities for improvement.

Table 13. Clinical PIP: Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Assessment of Clinical PIP Methodology
Standard 1: PIP Topic
Strengths: MCOs conducted and reported detailed research regarding the topic selection and its importance to members.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 2: PIP Aim Statement
Strengths: MCOs established clear, concise, measurable, and answerable aim statements.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 3: PIP Population
Strengths: MCOs clearly identified the PIP population in relation to the aim statements.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 4: Sampling Method
Strengths: Sampling was not utilized for these PIPs. This section is not applicable.
Weaknesses/Opportunities for Improvement: Sampling was not utilized for these PIPs. This section is not applicable.
Recommendations: Sampling was not utilized for these PIPs. This section is not applicable.
Standard 5: PIP Variables and Performance Measures
Strengths: MCOs selected PIP variables and performance measures that were clear indicators of performance.

Assessment of Clinical PIP Methodology
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 6: Data Collection Procedures
Strengths: MCOs used valid and reliable procedures to collect the PIP data and inform its measurements.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 7: Data Analysis and Interpretation of PIP Results
Strengths: MCOs used appropriate techniques to analyze the PIP data and interpret the results.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 8: Improvement Strategies
Strengths: MCOs selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement. The MCOs detailed the effectiveness of all interventions used for the PIPs. See Appendix 2 for additional details on PIP interventions.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 9: Significant and Sustained Improvement
Strengths: MCOs utilized methodology that was likely to demonstrate significant and sustained improvement.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.

The following table identifies strengths, weaknesses/opportunities for improvement, and recommendations for the significant improvement validation for clinical PIPs validated.

Table 14. Clinical PIP Significant Improvement: Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Assessment of Clinical PIP Significant Improvement
Significant Improvement
Strengths: Most PIP results demonstrated significant improvements, that are likely attributed to the improvement strategies implemented during the measurement year.
Weaknesses/Opportunities for Improvement: None identified.

Assessment of Clinical PIP Significant Improvement
Recommendations: None identified.

The following table identifies strengths, weaknesses/opportunities for improvement and recommendations for non-clinical PIPs validated in FY 24-25. Strengths are given for standards that scored at or above 90 percent. Weaknesses, or opportunities for improvement, are included for any standard that is below 90 percent, and any scoring element that was not met for more than one organization. Additional opportunities for improvement may be included for elements that are minimally compliant. Recommendations are provided for all identified weaknesses and opportunities for improvement.

Table 15. Non-Clinical PIP: Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Assessment of Non-Clinical PIP Methodology
Standard 1: PIP Topic
Strengths: MCOs conducted and reported detailed research regarding the topic selection and its importance to members.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 2: PIP Aim Statement
Strengths: MCOs established clear, concise, measurable, and answerable aim statements.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 3: PIP Population
Strengths: MCOs clearly identified the PIP population in relation to the aim statements.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 4: Sampling Method
Strengths: Sampling was not utilized for these PIPs. This section is not applicable.
Weaknesses/Opportunities for Improvement: Sampling was not utilized for these PIPs. This section is not applicable.
Recommendations: Sampling was not utilized for these PIPs. This section is not applicable.
Standard 5: PIP Variables and Performance Measures

Assessment of Non-Clinical PIP Methodology
Strengths: MCOs selected PIP variables and performance measures that were clear indicators of performance.
Weaknesses/Opportunities for Improvement: Scoring element **5.1** assessed if the variables were adequate to answer the study question. Two MCOs used variables that did not align with the project aim statements. ***This scoring element was not met***.
Recommendations: Ensure the PIP variables are adequate to answer the aim statement **(5.1)**.
Standard 6: Data Collection Procedures
Strengths: MCOs used valid and reliable procedures to collect the PIP data and inform its measurements.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 7: Data Analysis and Interpretation of PIP Results
Strengths: MCOs used appropriate techniques to analyze the PIP data and interpret the results.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 8: Improvement Strategies
Strengths: MCOs selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement. The MCOs detailed the effectiveness of all interventions used for the PIPs. See Appendix 2 for additional details on PIP interventions.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 9: Significant and Sustained Improvement
Strengths: MCOs utilized methodology that was likely to demonstrate significant and sustained improvement.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.

The following table identifies strengths, weaknesses/opportunities for improvement, and recommendations for the significant improvement validation for non-clinical PIPs validated.

Table 16. Non-Clinical PIP Significant Improvement: Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Assessment of Non-Clinical PIP Significant Improvement
Significant Improvement
Strengths: Most PIP results demonstrated significant improvements, that are likely attributed to the improvement strategies implemented during the measurement year.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.

Validation of Performance Improvement Project – Managed Care Organization Level Findings

Community Care, Inc.

The following results provide an overview of the clinical and non-clinical PIPs submitted by CCI.

Table 17. CCI PIP Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Clinical and Non-Clinical
Strengths
• Conducted and reported detailed research regarding the topic selection and its importance to members for both projects. • Established a clear, concise, measurable, and answerable aim statement for both projects. • Clearly identified the PIP population in relation to the aim statement for both projects. • Selected PIP variables and performance measures that were clear indicators of performance for one project. • Used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. • Used appropriate techniques to analyze the PIP data and interpret the results for one project. • Selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. • Utilized methodology that was likely to demonstrate significant and sustained improvement for both projects.
Weaknesses/Opportunities for Improvement
• Scoring element **5.1** assessed if the variables were adequate to answer the study question. During the discussion call for the non-clinical PIP, MCO staff reported an average attendance rate of the quarterly MACs was calculated to account for the aims of sustaining attendance throughout the project timeframe. However, the variables to answer the study question in the report provide a point in time performance measure and not an average. ***This scoring element was not met***.

Clinical and Non-Clinical
• Scoring element **7.7** assessed if PIP results and findings were presented in a concise and easily understood manner. The aim statement for the clinical PIP referenced a baseline rate of 23 percent. However, due to the addition of new data fields, the baseline compliance rate was updated to 22 percent. The aim statement was not updated to include the new baseline compliance rate. Additionally, there was an inconsistency within the report related to the baseline denominator rate. Two different baseline denominator rates were referenced within the report, making findings unclear. ***This scoring element was not met***. • The PIP results for one of the non-clinical aims did not demonstrate significant improvement. Changes in rates are likely due to normal variation or chance. ***Significant Improvement was not met***.
Recommendations
• Identify and define variables that are adequate to answer the study questions **(5.1)**. • Update the aim statement when there is a change in the baseline rate, and ensure project findings are presented in a concise and easily understood manner **(7.7)**. • Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care **(Significant Improvement)**.

Independent Care Health Plan

The following results provide an overview of the clinical and non-clinical PIPs submitted by *i*Care.

Table 18. *i*Care PIP Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Clinical and Non-Clinical
Strengths
• Conducted and reported detailed research regarding the topic selection and its importance to members for all projects. • Established a clear, concise, measurable, and answerable aim statement for all projects. • Clearly identified the PIP population in relation to the aim statement for all projects. • Selected PIP variables and performance measures that were clear indicators of performance for all projects. • Used valid and reliable procedures to collect the PIP data and inform its measurements for all projects. • Used appropriate techniques to analyze the PIP data and interpret the results for all projects. • Selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for all projects. • Utilized methodology that was likely to demonstrate significant and sustained improvement for all projects.

Clinical and Non-Clinical
• Demonstrated significant improvement that may likely be the result of selected interventions for all projects.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Lakeland Care, Inc.

The following results provide an overview of the clinical and non-clinical PIPs submitted by LCI.

Table 19. LCI PIP Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Clinical and Non-Clinical
Strengths
• Conducted and reported detailed research regarding the topic selection and its importance to members for both projects. • Established a clear, concise, measurable, and answerable aim statement for both projects. • Clearly identified the PIP population in relation to the aim statement for one project. • Used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. • Used appropriate techniques to analyze the PIP data and interpret the results for both projects. • Selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. • Utilized methodology that was likely to demonstrate significant and sustained improvement for both projects. • Demonstrated significant improvement that may likely be the result of selected interventions for both projects.
Weaknesses/Opportunities for Improvement
• Scoring element **3.1** evaluated whether the project population was clearly identified in terms of the identified PIP question. The PIP population for the clinical PIP was noted in the report as members who received care management services from nurse care manager staff supervised by the five identified LCI supervisors, whose nurse care manager received the project intervention of education. The requirement of nurse care manager staff to have completed the intervention of education did not align with the PIP population stated in the aim statement. During the discussion call, MCO staff identified after the project was completed, they adjusted the PIP report from the initial proposal report. They identified all nurse care management staff under the five identified supervisors received the intervention of the education, so all members receiving services from the nurse care

Clinical and Non-Clinical
managers were part of the project population. The defined study population did not align with the PIP population noted in the aim statement. ***This scoring element was not met***. • Scoring element **5.1** assessed if the variables were adequate to answer the study question. The defined denominator for the clinical PIP variable was noted as the number of LCI Target Group 1 members whose nurse care manager received the intervention. The requirement of nurse care manager staff to have received the intervention did not align with the PIP population identified in the aim statement. During the discussion call, MCO staff stated after the project was completed, the PIP report was adjusted from the initial proposal report. They identified all nurse care manager staff under the five identified supervisors received the intervention of the education, so all members in Target Group 1 were part of the denominator measure. However, the defined denominator for the project variable did not align with the PIP population noted in the aim statement. ***This scoring element was not met***. • Scoring element **8.1** required improvement strategies to be evidence-based, suggesting the test of change would likely lead to the desired improvement in processes or outcomes. As a result of a PDSA cycle for the non-clinical PIP, the MCO added a second intervention of mailing a reminder post card to members who did not have APOA-HC documentation scanned into their record. During the interview, LCI described the use of postcard mailings with other projects in the past and noted the success of this intervention. However, this information was not included in the PIP report. ***This scoring element was not met***.
Recommendations
• Ensure the project population is clearly identified in terms of the identified PIP question. **(3.1)** • Ensure the PIP variables are adequate to answer the aim statement. **(5.1)** • Include documentation in the PIP report describing how all improvement strategies are evidenced-based. **(8.1)**

My Choice Wisconsin

The following results provide an overview of the clinical and non-clinical PIPs submitted by MCW.

Table 20. MCW PIP Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Clinical and Non-Clinical
Strengths
• Conducted and reported detailed research regarding the topic selection and its importance to members for both projects. • Established a clear, concise, measurable, and answerable aim statement for both projects. • Clearly identified the PIP population in relation to the aim statement for both projects.

Clinical and Non-Clinical
• Selected PIP variables and performance measures that were clear indicators of performance for both projects. • Used valid and reliable procedures to collect the PIP data and inform its measurements for both projects. • Used appropriate techniques to analyze the PIP data and interpret the results for both projects. • Selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for both projects. • Utilized methodology that was likely to demonstrate significant and sustained improvement for both projects. • Demonstrated significant improvement that may likely be the result of selected interventions for one project.
Weaknesses/Opportunities for Improvement
• The PIP results for the clinical PIP did not demonstrate significant improvement. Changes in rates are likely due to normal variation or chance. ***Significant Improvement was not met***.
Recommendations
• Utilize improvement strategies that are likely to lead to statistical improvement in processes or outcomes of care for each project **(Significant Improvement)**.

Validation of Performance Improvement Projects - Progress on Prior Recommendations

MetaStar assessed the degree that the organization effectively addressed recommendations for quality improvement made during the previous review. The following rating scale was applied.

Table 21. Degree to Which the Organizations Addressed the Recommendations

Degree	Description
High	The organization addressed all recommendations.
Medium	The organization addressed half of the recommendations, but not all.
Low	The organization addressed less than half of the recommendations.
N/A	No recommendations received.

The following table identifies the state-level recommendations made in the prior review, the actions taken to address the recommendations, and the degree to which the organizations addressed the recommendations. If no actions were taken, or were insufficient to address the recommendation, they will not be listed in the corresponding column.

Table 22. State-Level Progress

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
– Ensure the same methodology is used to calculate the baseline and repeat measurements for each project **(9.1)**. – Implement improvement strategies that will lead to the desired improvements in the selected topic **(Significant Improvement)**.	– All projects conducted utilized the same methodology to calculate the baseline and repeat measurements **(9.1)**.	Medium

The table below identifies the recommendations made by the EQRO in the prior review, FY 23-24, the actions taken by the MCOs to address the recommendations, and the degree to which the MCOs addressed the recommendations. If no actions were taken, or were insufficient to address the recommendation, they will not be listed in the corresponding column.

Table 23. MCO-Level Progress

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCI	– Clearly define all inclusion and exclusion criteria **(3.1)**. – Ensure projects capture data on the variables **(5.3)**. – Include a strategy for interrater reliability for data collection **(5.9)**. – Include a process to validate the accuracy and completeness of data generated from the electronic care management system **(6.6)**. – Account for any factors that may influence comparability of initial and repeat measures **(7.4)**.	– The organization clearly defined all inclusion and exclusion criteria **(3.1)**. – The organization ensured the projects captured data on the variables **(5.3)**. – The organization included a strategy for interrater reliability for data collection **(5.9)**. – The organization included a process to validate the accuracy and completeness of data generated from the electronic care management system **(6.6)**.	High

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Include rationale for selecting improvement strategies **(8.1)**. – Implement a process to ensure a consistent methodology for both the baseline and repeat measurement **(9.1)**.	– The organization accounted for factors that could influence comparability of initial and repeat measures **(7.4)**. – The organization included evidence-based rationale for selecting improvement strategies **(8.1)**. – The organization implemented a process to ensure a consistent methodology for both the baseline and repeat measurement **(9.1)**.	
*i*Care	– Ensure the focus and basic framework of the project aligns with the aim statement **(2.4)**. – Summarize the components of the aim statement into a concise, brief statement **(2.4)**. – Document the process to validate the accuracy and completeness of data generated from the electronic care management system **(6.13)**. – Present results and findings in a concise and easily understood manner **(7.7)**. – Document the results of continuous cycles of improvement **(8.3)**. – Ensure reports build on findings from the data analysis and include interpretation of results, including the extent to which the	– The organization ensured the focus and framework of the project aligned with the aim statement **(2.4)**. – The organization ensured the aim statement was concise **(2.4)**. – The organization documented the process to validate the accuracy and completeness of data generated from the electronic care management system **(6.13)**. – The organization presented results and findings in a concise and easily understood manner **(7.7)**. – The organization documented the results of continuous cycles of improvement **(8.3)**. – The organization provided an interpretation of PIP results and included an assessment of the	High

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	improvement strategies were successful **(8.6)**. – Continue to build a methodologically sound performance improvement project to ensure quantitative improvement is demonstrated from baseline to repeat rates **(9.2)**. – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care **(9.3)**.	effectiveness of the improvement strategies **(8.6)**. – The organization developed a methodologically sound performance improvement project that demonstrated quantitative improvement from baseline to repeat rates **(9.2)**. – The organization implemented improvement strategies that were likely to lead to the desired improvement in processes or outcomes of care **(9.3)**.	
LCI	– Ensure the PIP variables are consistent with the aim statement **(5.1)**. – Develop and implement a process to ensure a consistent methodology for both the baseline and repeat measurement **(9.1)**. – Use consistent methodology for baseline and repeat measures to demonstrate methodologically sound improvement **(9.2)**. – Use consistent methodology to calculate baseline and repeat measures to assess the effectiveness of improvement strategies **(9.3)**. – Use consistent methodology to calculate baseline and repeat measures to assess statistical evidence that improvements are	– The organization implemented a process to ensure consistent methodology for both baseline and repeat measurement **(9.1)**. – The organization used consistent methodology for baseline and repeat measures to demonstrate methodologically sound improvement **(9.2)**. – The organization used consistent methodology to calculate baseline and repeat measures to assess the effectiveness of improvement strategies **(9.3)**. – The organization used consistent methodology to calculate baseline and repeat measures to assess statistical evidence that improvements are the result of the interventions **(9.4)**.	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	the result of the interventions **(9.4)**.		
MCW	– Ensure the aim statement is concise and does not include extraneous information in this section that could detract from the focus of the project **(2.4)**. – Ensure analysis focuses on the current project and findings are clearly connected to the aim **(7.7)**. – Include assessment of the effectiveness of the improvement strategies and identify potential follow-up activities **(8.6)**. – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care **(9.3)**.	– The organization ensured the aim statement was concise **(2.4)**. – The organization focused analysis on the current project and findings were clearly connected to the aim **(7.7)**. – The organization included an assessment of the effectiveness of the improvement strategies and identified potential follow-up activities **(8.6)**. – The organization implemented improvement strategies that were likely to lead to the desired improvement in processes or outcomes of care **(9.3)**.	High

Protocol 2: Validation of Performance Measures

The validation of MCOs' and PIHPs' performance measures is a mandatory EQR activity identified in 42 CFR § 438.358. Review activities are conducted according to federal protocol. See Appendix 1 for more information about the PMV review methodology.

The MCO quality indicators for MY 2024, which are set forth in Addendum III of the 2024 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 2024. The technical definitions provided by DHS for the MY influenza and pneumococcal vaccination quality indicators include a definition of the MY. The technical definitions are in Appendix 3.

Table 24. State Performance Measures

Performance Measures	Description	Numerator	Denominator
Influenza Vaccination Rate	This measure is used to assess the percentage of FC, FCP, and PACE members who received an influenza immunization from July 1 to March 31.	Number of members in the denominator with evidence of a seasonal influenza vaccine given from July 1 to March 31.	Number of members continuously enrolled from July 1 to March 31.
Pneumococcal Vaccination Rate	This measure assesses the percentage of FC, FCP, and PACE members age 65 and older who have *ever* received a pneumococcal immunization.	The number of members in the denominator with documentation of ever having been given a pneumococcal vaccine. Include any pneumococcal immunization encounter for each member.	Total number of members aged 65 and older continuously enrolled from July 1 to December 31 of the measurement year.

While acute and primary care services, including vaccinations, are covered under the PACE and FCP benefit packages, but not under FC, all three programs are expected to coordinate long-term care with preventive health services. Care managers across PACE, FCP, and FC play a vital role in supporting this coordination by assisting members in accessing preventive services, such as vaccinations, to promote wellness and help members maintain their health.

Assessment of each 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 ISCA once every three years as directed by DHS. The ISCAs are conducted and reported in a separate section of this report. The review methodology MetaStar used to validate these performance measures are in Appendix 1.

Validation of Performance Measures - Results

This report addresses the compliance with PMV requirements for the review periods identified in the table above, with validations conducted in FY 24-25. Compliance with PMV requirements is reported in terms of a percentage score and a compliance rating identified in the table below. See Appendix 1 for more information about the scoring methodology.

Table 25. PMV Scoring Legend

Score	Compliance Rating
90.0% - 100.0%	Fully Met
80.0% - 89.9%	Substantially Met
70.0% - 79.9%	Partially Met
60.0% - 69.9%	Minimally Met
≤59.9%	Not Met

Influenza Vaccination Rates

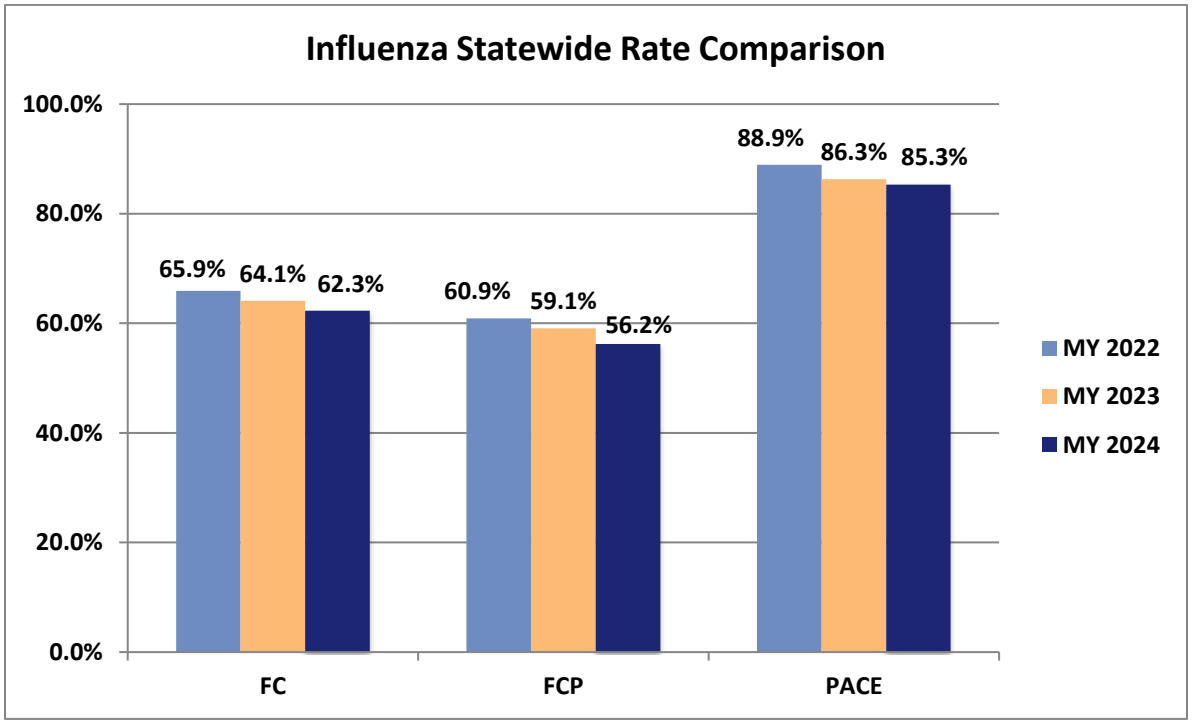
The following table displays the influenza vaccination rates, by program, for MY 2024 and compares the MY 2024 rates to vaccination rates in MY 2023.

Table 26. State Level Influenza Vaccination Rates by Program and Measurement Year

Program	Eligible Members	Number Vaccinated	MY 2024 Vaccination Rate	Compliance Rating	MY 2023 Vaccination Rate
FC	44,998	28,025	62.3%	Minimally Met	64.1%
FCP	2,805	1,577	56.2%	Not Met	59.1%
PACE	402	343	85.3%	Substantially Met	86.3%

Influenza vaccination statewide rates, by program, for MY 2024 and MY 2023 are shown in the following graph.

Chart 4. State Level Influenza Vaccination Rates by Program and Measurement Year



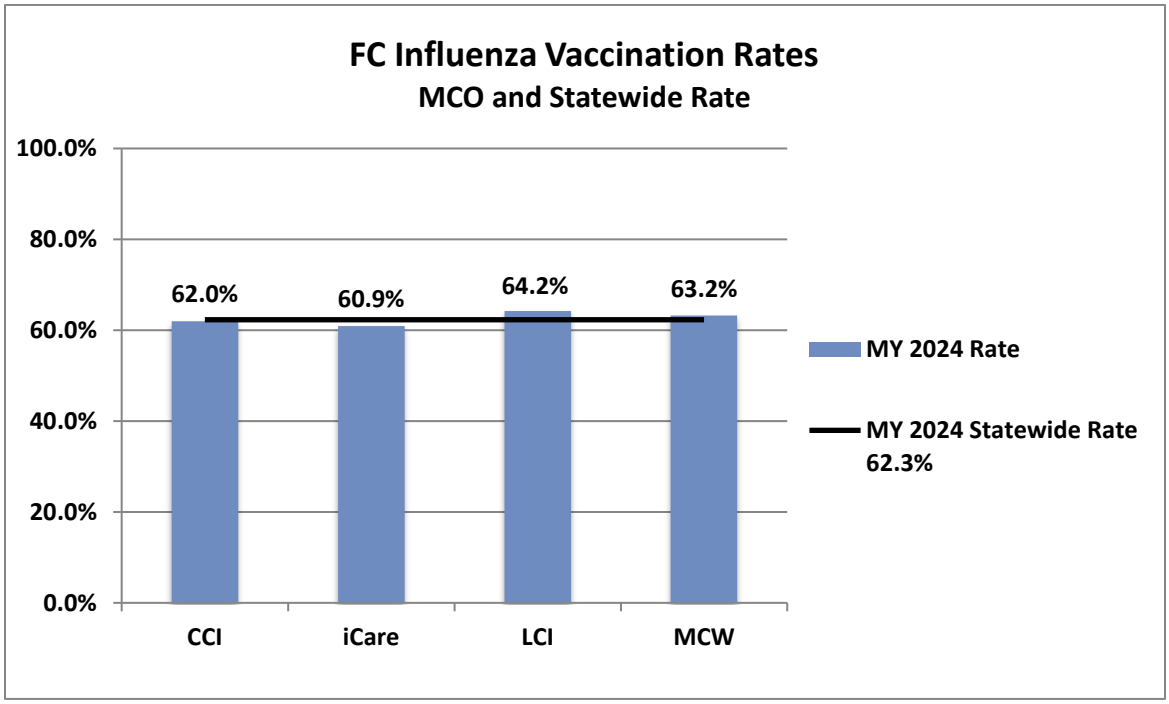
The table below shows influenza vaccination rates for the FC program by MCO for MY 2024 and MY 2023.

Table 27. FC Influenza Vaccinations Rates by MCO and Measurement Year

MCO	Eligible Members	Number Vaccinated	MY 2024 Vaccination Rate	Compliance Rating	MY 2023 Vaccination Rate
CCI	11,627	7,210	62.0%	Minimally Met	63.3%
***i*Care**	14,537	8,852	60.9%	Minimally Met	63.0%
LCI	6,129	3,935	64.2%	Minimally Met	66.4%
MCW	12,705	8,028	63.2%	Minimally Met	64.8%

FC influenza vaccination rates, by MCO, for MY 2024 and MY 2023 are shown in the following graph. The state rate for MY 2024 is included on the graph.

Chart 5. FC Influenza Vaccination Rates by MCO and Measurement Year

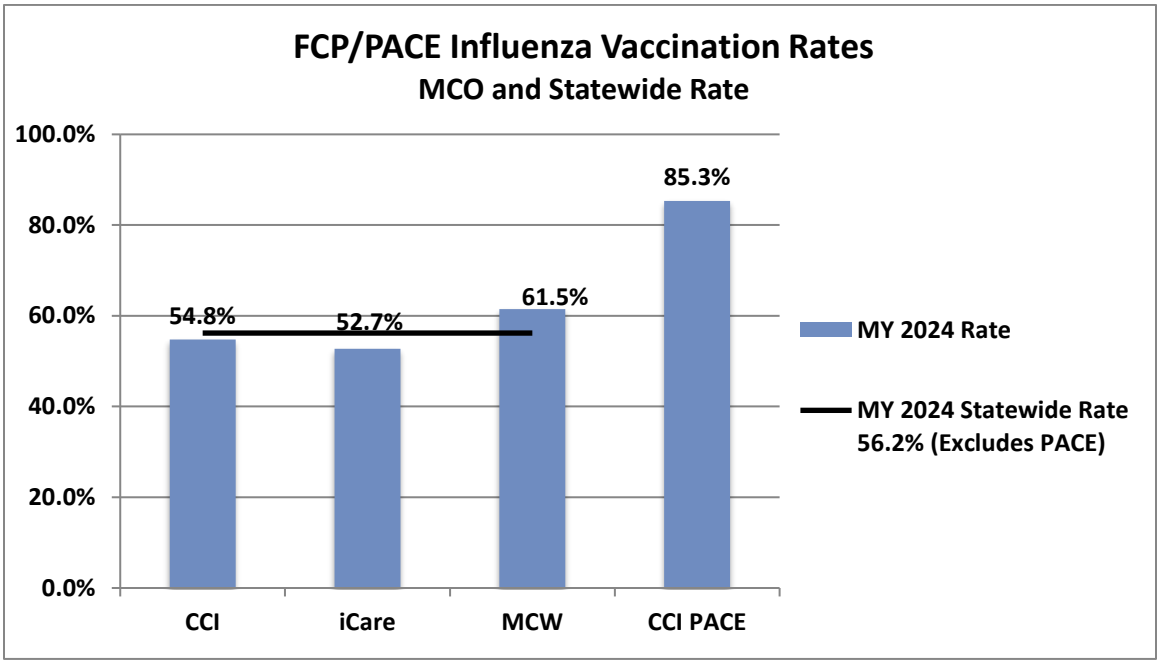


The table below shows influenza vaccination rates for the FCP and PACE programs by MCO for MY 2024 and MY 2023. Only one MCO operates the PACE program; therefore, here and in subsequent graphs in this report, no PACE statewide rate is available for comparison.

Table 28. FCP and PACE Influenza Vaccinations Rates by MCO and Measurement Year

MCO	Eligible Members	Number Vaccinated	MY 2024 Vaccination Rate	Compliance Rating	MY 2023 Vaccination Rate
CCI - FCP	577	316	54.8%	Not Met	60.2%
***i*Care**	1,241	654	52.7%	Not Met	51.9%
MCW	987	607	61.5%	Minimally Met	66.9%
CCI - PACE	402	343	85.3%	Substantially Met	86.3%

Chart 6. FCP and PACE Influenza Vaccination Rates by MCO and Measurement Year



Pneumococcal Vaccination Rates

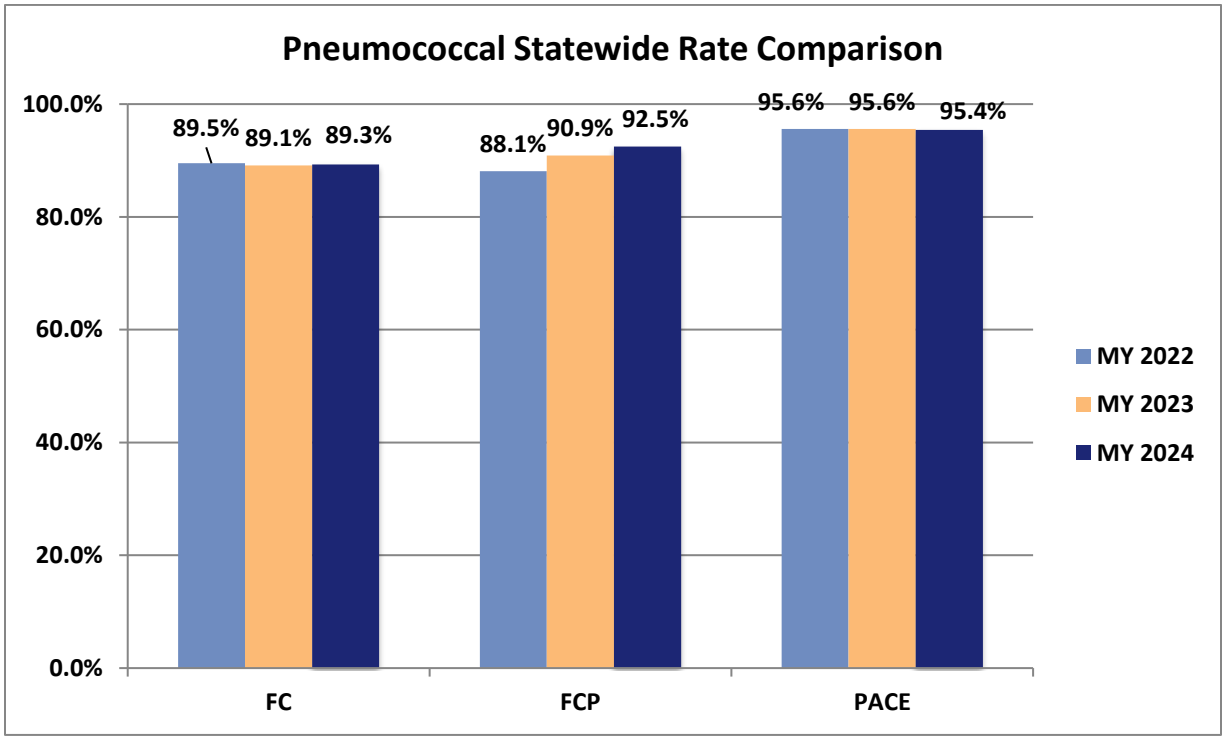
The following table displays the pneumococcal vaccination rates, by program, for MY 2024 and compares the MY 2024 rates to vaccination rates in MY 2023.

Table 29. State Level Pneumococcal Vaccination Rates by Program and Measurement Year

Program	Eligible Members	Number Vaccinated	MY 2024 Vaccination Rate	Compliance Rating	MY 2023 Vaccination Rate
FC	20,755	18,531	89.3%	Substantially Met	89.1%
FCP	1,310	1,212	92.5%	Fully Met	90.9%
PACE	390	372	95.4%	Fully Met	95.6%

Influenza vaccination statewide rates, by program, for MY 2024 and MY 2023 are shown in the following graph.

Chart 7. State Level Pneumococcal Vaccination Rates by Program and Measurement Year



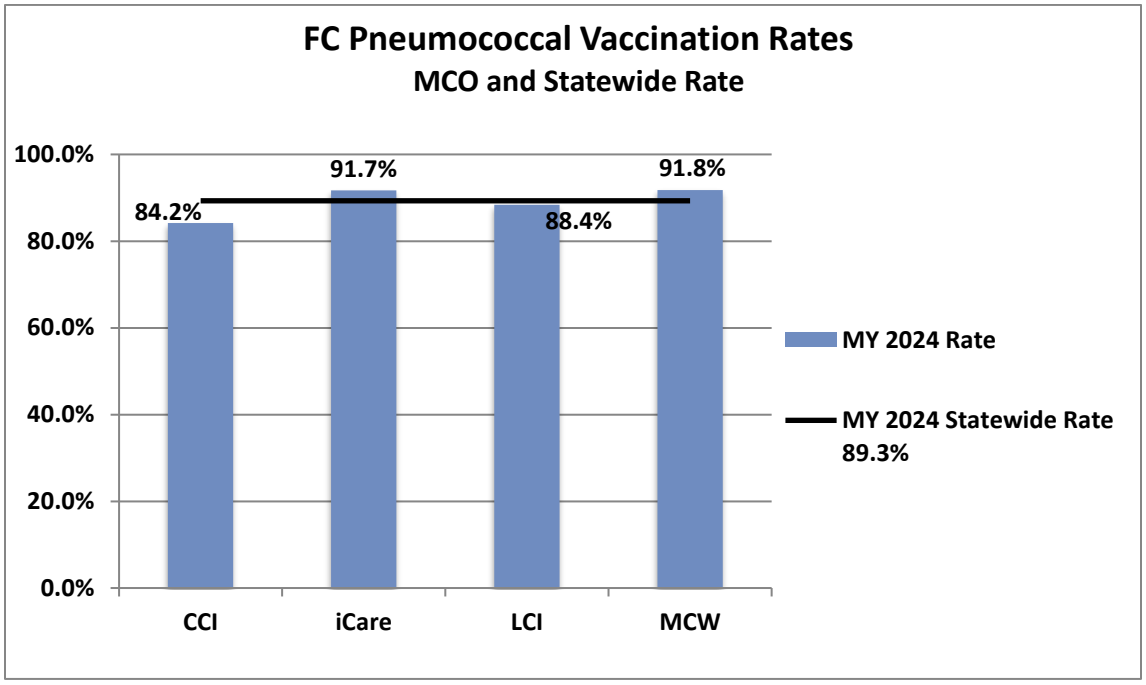
The table below shows pneumococcal vaccination rates for the FC program by MCO for MY 2024 and MY 2023.

Table 30. FC Pneumococcal Vaccinations Rates by MCO and Measurement Year

MCO	Eligible Members	Number Vaccinated	MY 2024 Vaccination Rate	Compliance Rating	MY 2023 Vaccination Rate
CCI	5,613	4,725	84.2%	Substantially Met	83.5%
***i*Care**	6,290	5,769	91.7%	Fully Met	91.7%
LCI	2,598	2,297	88.4%	Substantially Met	88.9%
MCW	6,254	5,740	91.8%	Fully Met	91.2%

FC pneumococcal vaccination rates, by MCO, for MY 2024 and MY 2023 are shown in the following graph. The state rate for MY 2024 is included on the graph.

Chart 8. FC Pneumococcal Vaccination Rates by MCO and Measurement Year

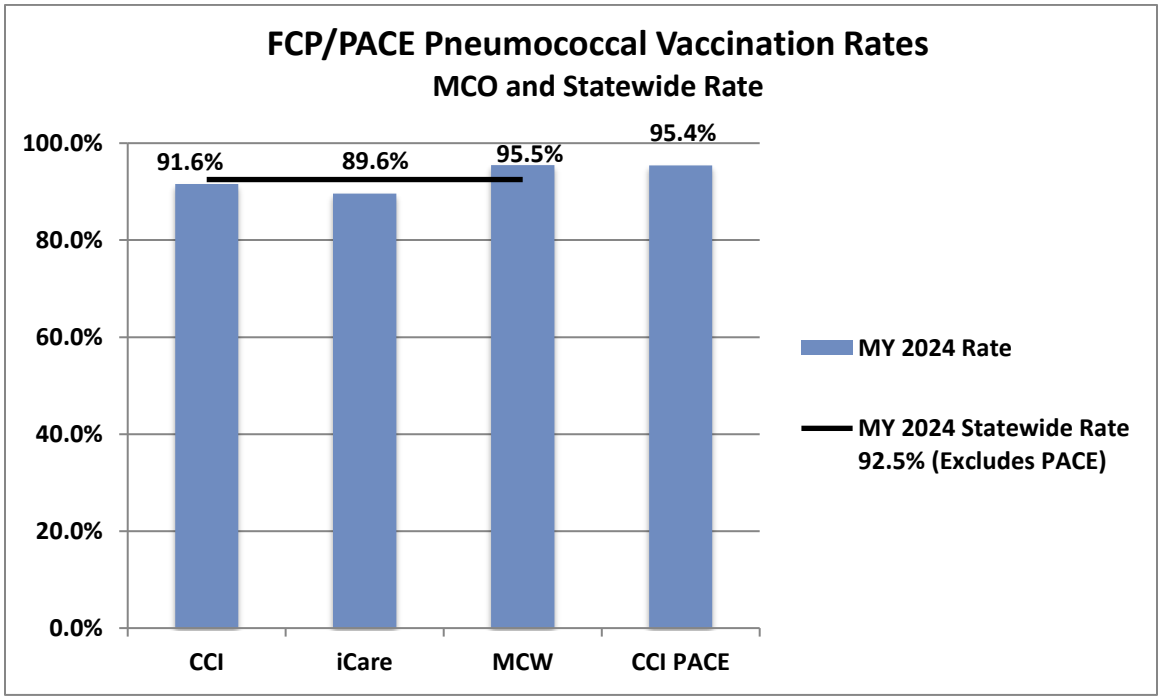


The table below shows pneumococcal vaccination rates for the FCP and PACE programs by MCO for MY 2024 and MY 2023.

Table 31. FCP and PACE Pneumococcal Vaccinations Rates by MCO and Measurement Year

MCO	Eligible Members	Number Vaccinated	MY 2024 Vaccination Rate	Compliance Rating	MY 2023 Vaccination Rate
CCI - FCP	226	207	91.6%	Fully Met	90.7%
***i*Care**	509	456	89.6%	Substantially Met	87.8%
MCW	575	549	95.5%	Fully Met	94.6%
CCI - PACE	390	372	95.4%	Fully Met	95.6%

Chart 9. FCP and PACE Pneumococcal Vaccination Rates by MCO and Measurement Year



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 2024. Whenever possible, the samples included 25 members reported to have received a vaccination and five members reported to have a contraindication to the vaccination. All FC MCOs and the PACE MCO reported members with contraindications for the influenza vaccine. Two FC MCOs reported members with contraindications for the pneumococcal vaccine. All FCP MCOs reported no members with contraindications for both of the quality indicators.

As shown in the following tables, MetaStar reviewed a total of 240 member vaccination records for each quality indicator for MY 2024. 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 2024 were not biased, meaning the rates can be accurately reported.

The overall findings for the *Quality Indicator: Pneumococcal Vaccination* for MY 2024 were biased, meaning the rates cannot be accurately reported.

Table 32. State Level Vaccination Record Validation Results

Quality Indicator	Total Records Reviewed	Number Valid	Percentage Valid	T-Test Result
Influenza Vaccinations	240	234	97.5%	Unbiased
Pneumococcal Vaccinations	240	236	98.3%	Biased

The following tables display the results for each quality indicator by program and MCO.

Table 33. FC Results for Influenza Vaccination by MCO

MCO	Total Records Reviewed	Number Valid	Percentage Valid	T-Test Result
CCI	30	30	100.0%	Unbiased
***i*Care**	30	30	100.0%	Unbiased
LCI	30	28	93.3%	Unbiased
MCW	30	30	100.0%	Unbiased

Table 34. FCP and PACE Results for Influenza Vaccination by MCO

MCO	Total Records Reviewed	Number Valid	Percentage Valid	T-Test Result
CCI - FCP	30	30	100.0%	Unbiased
iCare	30	26	86.7%	Unbiased
MCW	30	30	100.0%	Unbiased
CCI - PACE	30	30	100.0%	Unbiased

Table 35. FC Results for Pneumococcal Vaccination by MCO

MCO	Total Records Reviewed	Number Valid	Percentage Valid	T-Test Result
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

Table 36. FCP and PACE Results for Pneumococcal Vaccination by MCO

MCO	Total Records Reviewed	Number Valid	Percentage Valid	T-Test Result
CCI - FCP	30	30	100.0%	Unbiased

MCO	Total Records Reviewed	Number Valid	Percentage Valid	T-Test Result
***i*Care**	30	26	86.7%	Biased
MCW	30	30	100.0%	Unbiased
CCI - PACE	30	30	100.0%	Unbiased

Validation of Performance Measures - State Level Findings

The following table identifies strengths, weaknesses/opportunities for improvement, and recommendations for the performance measures validated in FY 24-25. Strengths from the performance measure validation are defined as quality indicator rates at or above 90 percent. Weaknesses, or opportunities for improvement, are included for any quality indicator rate that is below 90 percent. Recommendations are provided for all identified weaknesses and opportunities for improvement.

Table 37. PMV Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Influenza Vaccination Rate
Strengths
• None identified.
Weaknesses/Opportunities for Improvement
• Influenza rates have declined for five consecutive years, with Family Care experiencing a statistically significant decline in the prior three measurement years when compared to vaccination rates from the prior year.
Recommendations
• Conduct a root cause analysis to identify the reason for declining influenza vaccination rates for all programs. • Continue efforts to increase influenza vaccination rates by monitoring MCO efforts to educate members on the benefits of the vaccination.
Pneumococcal Vaccination Rate
Strengths
• The FCP and PACE programs demonstrated practices to ensure members receive pneumococcal vaccinations after the age of 65.
Weaknesses/Opportunities for Improvement
• Although the FC program results for the pneumococcal vaccination improved slightly from the previous measurement year, the rate remains below 90 percent, indicating opportunities for improvement.
Recommendations
• Continue efforts to increase pneumococcal vaccination rates, specifically for the FC program, by monitoring MCO efforts to educate members on the benefits of the vaccination.

To ensure the accuracy and reliability of reported performance data, additional validation procedures were implemented beyond the standard review process. These enhanced steps included denominator file comparisons to verify population counts and eligibility, detailed record-level validation to confirm data accuracy, and a thorough review of submitted policies and procedures. Additionally, each submission was assessed for compliance with the applicable technical specification and definitions. These supplemental checks help identify discrepancies early, promote alignment with program requirements, and support high-quality, reliable reporting across all MCOs and programs. The findings of these evaluations are identified in the following table.

Table 38. Data Integrity, Compliance, and Procedural Validation Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

DHS Denominator Comparison
Strengths
• For all MCOs and programs, more than 99 percent of the total number of unique members included in the MCOs' and DHS' influenza and pneumococcal denominator files were common to both data sets.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.
Vaccination Record Validation
Strengths
• The overall findings for the Quality Indicator: Influenza Vaccination for MY 2024 were not biased, meaning the rates can be accurately reported.
Weaknesses/Opportunities for Improvement
• Documentation efforts for one organization, *i*Care, incorrectly reported members received an influenza or pneumococcal vaccination while also noting the members declined the vaccine. This same organization identified members received a pneumococcal vaccination but did not document the date of immunization. These documentation challenges resulted in the overall findings for the Quality Indicator: Pneumococcal Vaccination for MY 2024 to be biased, meaning the rates cannot be accurately reported.
Recommendations
• Direct MCOs to develop processes to ensure interdisciplinary team staff understand and adhere to the organizations' policies and procedures for documentation of influenza and pneumococcal vaccination dates to enable rates to be accurately reported.
Technical Definition Compliance
Strengths
• All MCOs' vaccination data were found to be compliant with the technical definitions for both quality indicators.
Weaknesses/Opportunities for Improvement

DHS Denominator Comparison
Strengths
• For all MCOs and programs, more than 99 percent of the total number of unique members included in the MCOs' and DHS' influenza and pneumococcal denominator files were common to both data sets.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.
Vaccination Record Validation
• None identified.
Recommendations
• None identified.
Vaccination Policies and Procedures
Strengths
• MCO documentation included guidance to interdisciplinary staff for documenting members' vaccination status in their respective electronic care management documentation system.
Weaknesses/Opportunities for Improvement
• Documentation from two organizations, *i*Care and LCI, did not incorporate a definition of acceptable contraindications as noted in the *DHS Technical Definition* document for each vaccine.
Recommendations
• Ensure MCOs' vaccination policies and procedures include allowable contraindications and precautions to align with the *DHS Technical Definition.*

Validation of Performance Measures – Managed Care Organization Level Findings

Community Care, Inc.

The following results provide an overview of the validation conducted for CCI.

Table 39. CCI PMV Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

MCO Level
Strengths
• The FCP and PACE programs demonstrated practices to ensure members receive pneumococcal vaccinations after the age of 65.
Weaknesses/Opportunities for Improvement
• Influenza rates have declined for five consecutive years, with Family Care experiencing a statistically significant decline in the prior two measurement years when compared to vaccination rates from the prior year.

MCO Level
• Although the FC program results for the pneumococcal vaccination improved slightly from the previous measurement year, the rate remains below 90 percent, indicating opportunities for improvement.
Recommendations
• Continue efforts to increase influenza vaccination rates for FC, FCP, and PACE programs. • Continue efforts to increase pneumococcal vaccination rates for the Family Care program.

Independent Care Health Plan

The following results provide an overview of the validation conducted for *i*Care.

Table 40. *i*Care PMV Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

MCO Level
Strengths
• The FC program demonstrated practices to ensure members receive pneumococcal vaccinations after the age of 65.
Weaknesses/Opportunities for Improvement
• Influenza rates have declined for five consecutive years, with Family Care experiencing a statistically significant decline when compared to vaccination rates from the prior year. • Documentation incorrectly reported members received an influenza vaccination while also noting the members declined the vaccine.
Recommendations
• Ensure care management staff understand and adhere to the organization's policies and procedures for documentation of vaccination dates. The organization should develop a means to verify that vaccination documentation aligns with the organization's policies and procedures. • Amend the FCP policies and procedures to include allowable precautions and contraindications as noted in the *DHS Technical Definition* documents for each vaccine. • Continue to develop improvement strategies for the FC and FCP programs to increase the influenza vaccination rate.

Lakeland Care, Inc.

The following results provide an overview of the validation conducted for LCI.

Table 41. LCI PMV Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

MCO Level
Strengths
• None identified.
Weaknesses/Opportunities for Improvement
• Influenza rates have declined for five consecutive years, with Family Care experiencing a statistically significant decline when compared to vaccination rates from the prior year.

MCO Level
Recommendations
• Update the policy to include instruction that a vaccination deferred by a physician should be counted as a contraindication. • Continue to develop improvement strategies to increase the influenza and pneumococcal vaccination rates.

My Choice Wisconsin

The following results provide an overview of the validation conducted for MCW.

Table 42. MCW PMV Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

MCO Level
Strengths
• The Family Care and Family Care Partnership programs demonstrated practices to ensure members receive pneumococcal vaccinations after the age of 65.
Weaknesses/Opportunities for Improvement
• Influenza rates have declined for five consecutive years, with Family Care experiencing a statistically significant decline when compared to vaccination rates from the prior year.
Recommendations
• Perform barrier and root cause analyses for the FC and FCP programs to determine the reasons influenza vaccination rates continue to decline year over year. • Continue to develop improvement strategies for the FC and FCP programs to increase the influenza vaccination rates.

Validation of Performance Measures - Progress on Prior Recommendations

MetaStar assessed the degree that the organizations effectively addressed recommendations for quality improvement made during the previous review. The following rating scale was applied.

Table 43. Degree to Which the Organizations Addressed the Recommendations

Degree	Description
High	The organizations addressed all recommendations.
Medium	The organizations addressed half of the recommendations, but not all.
Low	The organizations addressed less than half of the recommendations.
N/A	No recommendations received.

The table below identifies the state-level recommendations made in the prior review, the actions taken to address the recommendations, and the degree to which the organizations addressed the recommendations. If no actions were taken, or were insufficient to address the recommendation, they will not be listed in the corresponding column.

Table 44. State-Level Progress

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
– 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 vaccination rates from the year before. – Continue efforts to increase influenza vaccination rates by educating members on the benefits of the vaccination.	– In response to declining flu immunization rates, DHS engaged the MCO Quality Workgroup members, summarized their interventions, and incorporated key strategies, such as staff training, member education, targeted outreach, and provider partnerships, into the CMS 372 report, with ongoing monitoring and quality improvement efforts.	**Medium**

The table below identifies the recommendations made by the EQRO in the prior review, FY 23-24, the actions taken by the MCOs to address the recommendations, and the degree to which the MCO addressed the recommendations. If no actions were taken, or were insufficient to address the recommendation, they will not be listed in the corresponding column.

Table 45. MCO-Level Progress

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCI	– Conduct a root cause analysis for the Family Care influenza and pneumococcal vaccination rates that declined from MY 2022. The influenza vaccination rates declined for a fourth consecutive year in the Family Care program. Identifying the root cause or	– No progress was identified.	**Low**

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	causes will allow the organization to focus improvement efforts. – Continue efforts to increase influenza and pneumococcal vaccination rates.		
*i*Care	– Amend the Family Care Partnership 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. – Continue efforts to increase influenza and pneumococcal vaccination rates for both the Family Care and Family Care Partnership programs. – 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 *Adult Long Term Care Functional Screen* in early 2017.	– The influenza and pneumococcal vaccination rates for the Family Care Partnership program improved slightly from the previous year. – The organization reported only one member age 65 or older in the Physical Disability target group for the pneumococcal vaccination.	**Medium**
LCI	– Continue to develop improvement strategies to increase the influenza vaccination rate. – Continue to develop improvement strategies to increase the pneumococcal vaccination rate.	– No progress was identified.	**Low**
MCW	– Perform barrier and root cause analyses for the Family Care program to determine the reasons	– No progress was identified.	**Low**

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	influenza vaccination rates continue to decline year over year. – Continue to develop improvement strategies for the Family Care and Family Care Partnership programs to increase the influenza vaccination rate.		

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

The assessment of each MCOs' and PIHPs' compliance with federal standards is a mandatory EQR activity identified in 42 CFR § 438.358. Review activities are conducted according to federal protocol. See Appendix 1 for more information about the compliance review methodology.

The review assesses the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care and LTSS.

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

- Availability and use of HCBS as alternatives to institutional care, so individuals can receive the services they need in the most integrated setting appropriate;
- 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 and care planning, service authorization and coordination, and care management for LTSS. This includes authorization/utilization management for LTSS and any enrollee rights or protections related to care and service planning, such as conflict-free case management, self-direction of services, and appeal rights related to person-centered planning.

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 Systems standards in the second year. At the discretion of DHS, additional standards may be reviewed in any year of the cycle. The table below identifies the standards to be evaluated in each respective year.

Table 46. Year 1 - MCO Standards

42 CFR 438 (Managed Care)	42 CFR 457 (CHIP)	Standard Name
§ 438.56	§ 457.1212	Disenrollment: Requirements and limitations
§ 438.100	§ 457.1220	Enrollee rights and protections
§ 438.114	§ 457.1228	Emergency and post-stabilization services
§ 438.206	§ 457.1230(a)	Availability of services
§ 438.207	§ 457.1230(b)	Assurances of adequate capacity and services

42 CFR 438 (Managed Care)	42 CFR 457 (CHIP)	Standard Name
§ 438.208	§ 457.1230(c)	Coordination and continuity of care
§ 438.210	§ 457.1230(d)	Coverage and authorization of services
§ 438.214	§ 457.1233(a)	Provider selection
§ 438.224	§ 457.1230(c)	Confidentiality
§ 438.230	§ 457.1233(b)	Subcontractual relationships and delegation
§ 438.236	§ 457.1233(c)	Practice guidelines
§ 438.242	§ 457.1233(d)	Health information systems

Table 47. Year 2 – QAPI and Grievance Systems Standards

42 CFR § 438 (Managed Care)	42 CFR 457 (CHIP)	Standard Name
§ 438.228	§ 457.1260	Grievance and appeal systems
§ 438.330	§ 457.1240(b)	Quality assessment and performance improvement program

This fiscal year is the first year of the cycle, and MCO Standards were reviewed. The combined compliance score for all standards will be reported following the second year of the two-year cycle.

Compliance with Standards Review – Results

This report addresses the compliance with standards requirements for the review period of January 1, 2024 – December 31, 2024, with reviews conducted FY 24-25. Compliance is reported in terms of a percentage score, a star rating that correlates with the *DHS Score Card*, and a compliance rating identified in the table below.

Table 48. Compliance with Standards Scoring Legend

Score	Stars	Compliance Rating
95.0% - 100.0%	★★★★★	Fully Met
90.0% - 94.9%	★★★★½	Fully Met
85.0% - 89.9%	★★★★	Substantially Met
80.0% - 84.9%	★★★½	Substantially Met
75.0% - 79.9%	★★★	Partially Met
70.0% - 74.9%	★★½	Partially Met
65.0% - 69.9%	★★	Minimally Met

Score	Stars	Compliance Rating
60.0% - 64.9%	★½	Minimally Met
55.0%-59.9%	★	Not Met
≤ 54.9%	½	Not Met

The state-level overall compliance score was 94.0 percent, and a compliance rating of Fully Met. The score is based on the review of the MCO Standards for all MCOs. The definition of a scoring element rated as compliant can be found in Appendix 1 which includes the full implementation of written policies and procedures, education of relevant staff, and sufficient monitoring.

The table below indicates the state's overall level of compliance with each MCO standard reviewed. The results from the QAPI and Grievance Systems standards reviewed in FY 23-24 are located in Appendix 3.

Table 49. State Level Compliance with Standards Results - MCO Standards

Standard	Scoring Elements	Percentage	Stars	Compliance Rating
M1: Availability of services - § 438.206 Assurances of adequate capacity and services - § 438.207	27/29	93.1%	★★★★½	Fully Met
M2: Furnishing of services and timely access - § 438.206(c)(1)	28/28	100.0%	★★★★★	Fully Met
M3: Access and cultural considerations in services - § 438.206(c)(2)	16/16	100.0%	★★★★★	Fully Met
M4: Assurances of adequate capacity and services - § 438.207*	N/A	N/A	N/A	N/A
M5: Coordination and continuity of care, and confidentiality - §§ 438.208, 438.224	44/48	91.7%	★★★★½	Fully Met
M6: Additional coordination and continuity of care requirements - § 438.208(c)	36/40	90.0%	★★★★½	Fully Met
M7: Disenrollment: requirements and limitations - § 438.56	15/16	93.8%	★★★★½	Fully Met
M8: Coverage and authorization of services - §§ 438.210, 440.230, 438.441	43/43	100.0%	★★★★★	Fully Met

Standard	Scoring Elements	Percentage	Stars	Compliance Rating
Emergency and post-stabilization services - § 438.114				
M9: Information requirements for all enrollees - §§ 438.100(b)(2)(i), 438.10	44/48	91.7%	★★★★½	Fully Met
M10: Enrollee right to receive information on available provider options - §§ 438.100(b)(2)(iii), 438.102	16/16	100.0%	★★★★★	Fully Met
M11: Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint - §§ 438.100(b)(2)(iv) and (v), 438.3(j)	43/44	97.7%	★★★★★	Fully Met
M12: Compliance with other federal and state laws - § 438.100(d)	8/8	100.0%	★★★★★	Fully Met
M13: Provider selection - § 438.214	45/52	86.5%	★★★★	Substantially Met
M14: Subcontractual relationships and delegation - § 438.230	30/32	93.8%	★★★★½	Fully Met
M15: Practice guidelines - § 438.236	15/16	93.8%	★★★★½	Fully Met
M16: Health information systems - § 438.242*	N/A	N/A	N/A	N/A
Overall	**410/436**	**94.0%**	★★★★½	**Fully Met**

*M4 and M16 are evaluated through reviews that occur separate from the compliance review.

The table below displays each MCO's compliance score for each standard reviewed. The MCO level results from the QAPI and Grievance Systems standards reviewed in FY 23-24 are located in Appendix 3.

Table 50. MCO Compliance with Standards Comparison Results – MCO Standards

Standard	CCI	*i*Care	LCI	MCW
M1: Availability of services - § 438.206 Assurances of adequate capacity and services - § 438.207	87.5%	87.5%	100.0%	100.0%
M2: Furnishing of services and timely access - § 438.206(c)(1)	100.0%	100.0%	100.0%	100.0%
M3: Access and cultural considerations in services - § 438.206(c)(2)	100.0%	100.0%	100.0%	100.0%

Standard	CCI	*i*Care	LCI	MCW
M4: Assurances of adequate capacity and services - § 438.207*	N/A	N/A	N/A	N/A
M5: Coordination and continuity of care, and confidentiality - §§ 438.208, 438.224	91.7%	91.7%	91.7%	91.7%
M6: Additional coordination and continuity of care requirements - § 438.208(c)	90.0%	90.0%	90.0%	90.0%
M7: Disenrollment: requirements and limitations - § 438.56	100.0%	100.0%	75.0%	100.0%
M8: Coverage and authorization of services - §§ 438.210, 440.230, 438.441 Emergency and post-stabilization services - § 438.114	100.0%	100.0%	100.0%	100.0%
M9: Information requirements for all enrollees - §§ 438.100(b)(2)(i), 438.10	75.0%	91.6%	100.0%	100.0%
M10: Enrollee right to receive information on available provider options - §§ 438.100(b)(2)(iii), 438.102	100.0%	100.0%	100.0%	100.0%
M11: Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint - §§ 438.100(b)(2)(iv) and (v), 438.3(j)	100.0%	100.0%	90.9%	100.0%
M12: Compliance with other federal and state laws - § 438.100(d)	100.0%	100.0%	100.0%	100.0%
M13: Provider selection - § 438.214	84.6%	92.3%	92.3%	76.9%
M14: Subcontractual relationships and delegation - § 438.230	87.5%	100.0%	87.5%	100.0%
M15: Practice guidelines - § 438.236	100.0%	100.0%	75.0%	100.0%
M16: Health information systems - § 438.242*	N/A	N/A	N/A	N/A
Overall	**91.9%**	**95.5%**	**93.2%**	**95.5%**

Compliance with Standards Review - State Level Findings

The following table identifies strengths, weaknesses/opportunities for improvement and recommendations for each standard reviewed. Strengths are given for standards that scored at or above 90 percent, as well as practices identified through the provider file verification. Weaknesses, or opportunities for improvement, are included for any standard that is below 90 percent, and any scoring element that was not met for more than one organization. Additional opportunities for improvement may be included for elements that are minimally compliant.

Recommendations are provided for all identified weaknesses and opportunities for improvement.

Table 51. Compliance with Standards Strengths, Weaknesses/Opportunities for Improvement and Recommendations

State Level
M1: Availability of services - § 438.206 **Assurances of adequate capacity and services - § 438.207**
Strengths: The MCOs demonstrated compliance by ensuring that all services covered under the state plan were available and accessible to members in a timely manner. MCOs maintained and monitored a network of appropriate providers sufficient to meet the needs of all enrollees, including those with limited English proficiency and physical or mental disabilities. Female members were provided direct access to women's health specialists, and second opinions were made available at no cost. When network limitations occurred, the MCOs arranged for out-of-network services without additional cost to the members and ensured coordination for payment.
Weaknesses/Opportunities for Improvement: Scoring element **M1.8** required MCOs to maintain complete and current provider directory information on their websites. One MCO did not define circumstances under which a provider would be excluded from the directory, and another MCO did not establish timeframes for updating the directory when new providers were added. These requirements were not addressed in the respective policies. ***This scoring element was not met.***
Recommendations: Revise provider directory policies to clearly define circumstances under which a provider may be excluded from the directory and establish specific timeframes for updating directory information when new providers are added **(M1.8)**.
M2: Furnishing of services and timely access - § 438.206(c)(1)
Strengths: The MCOs maintained provider networks that deliver timely access to services. Providers met State availability standards and offer 24/7 access to medically necessary care. The organizations monitored performance and promptly addressed any deficiencies.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
M3: Access and cultural considerations in services - § 438.206(c)(2)
Strengths: The MCOs ensured culturally competent service delivery and promoted inclusive care by addressing the needs of enrollees with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and individuals of all sexes, gender identities, and sexual orientations. Through training, policy alignment, and continuous monitoring, the organizations fostered environments where all members receive respectful, responsive, and equitable care.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
M4: Assurances of adequate capacity and services - § 438.207

State Level
Requirements related to assurances of adequate capacity and services under are evaluated separately in Protocol 4 – Network Adequacy. Findings for these requirements can be reviewed in that section of the report.
M5: Coordination and continuity of care, and confidentiality -§§ 438.208, 438.224
Strengths: The MCOs implemented procedures that ensured coordinated, continuous care for all members, including those with special health care needs. MCOs facilitated communication across care settings to support transitions. Additionally, the organizations ensured that all medical records and health information were handled in accordance with federal privacy regulations, safeguarding member confidentiality throughout the care process.
Weaknesses/Opportunities for Improvement: Scoring element **M5.1** required MCOs to ensure coordination of long-term care services with health care services received by the member, as well as other services available from natural and community supports. Monitoring results from internal file reviews conducted by the MCOs, along with MetaStar's CMR, identified a system-wide need for improvement related to follow-up in the FC and FCP programs. ***This scoring element was not met.***
Recommendations: Strengthen coordination efforts between long-term care and health care services by improving follow-up practices in the FC and FCP programs. Continued monitoring and feedback mechanisms should be maintained to support consistent quality improvement across all organizations **(M5.1)**.
M6: Additional coordination and continuity of care requirements - § 438.208(c)
Strengths: The MCOs implemented procedures that supported comprehensive coordination and continuity of care for members. MCOs conducted timely screenings and assessments, developed individualized MCPs, and ensured that care was coordinated across settings, providers, and support systems. Individualized MCPs were developed and monitored to reflect enrollee needs and preferences. The organizations shared assessment results with relevant entities to prevent duplication and maintained clear communication with members.
Weaknesses/Opportunities for Improvement: Scoring element **M6.5** required the MCP to be based on the comprehensive assessment. IDT staff must involve the member and other parties in accordance with the member's preferences and the parties' ability to contribute to MCP development. Internal monitoring results related to the comprehensiveness of MCPs indicated a need for improvement in the FC and FCP programs for two MCOs. MetaStar's CMR results also supported this finding. ***This scoring element was not met.*** Scoring element **M6.10** required a fully developed MCP to be completed and signed by the member or the member's legal decision maker within 60 calendar days of the enrollment date. Internal monitoring results related to the timely completion and signing of MCPs indicated a need for improvement for two MCOs, as did MetaStar's CMR findings. ***This scoring element was not met.***

State Level
Recommendations: Enhance the development of MCPs by ensuring they are fully informed by comprehensive assessments and reflect meaningful involvement of the member and relevant parties. Focused training and oversight may support improved compliance with this requirement **(M6.5)**. Prioritize timely completion and signing of initial MCPs within 60 days of enrollment. Continued monitoring and targeted process improvements are recommended to ensure compliance with this requirement **(M6.10)**.
M7: Disenrollment: requirements and limitations - § 438.56
Strengths: The organizations ensured disenrollment processes were fair, transparent, and consistent with federal guidelines. Members are informed of their rights to request disenrollment for cause at any time. The organizations documented and monitored disenrollment requests to ensure they align strictly with permitted reasons.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
M8: Coverage and authorization of services - §§ 438.210, 440.230, 438.441 **Emergency and post-stabilization services - § 438.114**
Strengths: The MCOs consistently upheld state standards by ensuring that all covered services were medically necessary, appropriately authorized, and delivered in accordance with federal requirements. MCOs maintained clear criteria for service authorization, provided timely decisions, and ensured that denials included adequate notice and appeal rights. Emergency and post-stabilization services were reliably covered and paid for, regardless of provider network status, ensuring members received immediate care without delay or financial liability.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
M9: Information requirements for all enrollees - §§ 438.100(b)(2)(i), 438.10
Strengths: The MCOs demonstrated compliance by ensuring that all members received timely, accurate, and accessible information necessary to make informed decisions about their care. Information was provided in a culturally and linguistically appropriate manner, including alternative formats and languages as required. Materials covered enrollee rights, benefits, provider networks, and service availability, and were distributed in accordance with federal timelines.
Weaknesses/Opportunities for Improvement: Scoring Element **M9.9** required that members can request electronic materials in paper form without charge, and the organizations are to provide these materials to members within five business days. One MCO lacked written guidance on obtaining member consent for electronic materials, while another MCO did not include the five-day timeframe in its policy documents. ***This scoring element was not met.***
Recommendations: Update policy documents to include procedures for obtaining member consent to receive electronic materials and ensure the required five-day timeframe for providing paper copies is

State Level
clearly stated. Staff training should reinforce these requirements to support consistent implementation **(M9.9)**.
M10: Enrollee right to receive information on available provider options - §§ 438.100(b)(2)(iii), 438.102
Strengths: The MCOs ensured that members consistently received clear, accurate, and accessible information about available provider options. Information was presented in a manner appropriate to each member's condition and ability to understand, enabling informed decision-making. The organizations complied with federal standards by providing both oral and written materials that supported transparency and respected individual preferences, thereby reinforcing member autonomy and equitable access to care.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
M11: Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint - §§ 438.100(b)(2)(iv) and (v), 438.3(j)
Strengths: The MCOs upheld requirements by ensuring that members were actively involved in decisions regarding their care and were protected from any form of restraint or seclusion used for coercion, discipline, convenience, or retaliation. Documentation demonstrated that members were consistently informed of their rights and supported in exercising autonomy over their treatment choices. Additionally, the review of restrictive measures logs from most MCOs confirmed compliance with renewal timelines, further reinforcing the commitment to safeguarding enrollee rights and maintaining regulatory standards.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
M12: Compliance with other federal and state laws - § 438.100(d)
Strengths: The MCOs demonstrated consistent compliance by ensuring that all contracted entities adhered to applicable federal and state laws protecting enrollee rights. This included alignment with civil rights protections under Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, Titles II and III of the Americans with Disabilities Act, and Section 1557 of the Affordable Care Act. Policies and procedures were in place to ensure that staff and providers observed these legal standards, reinforcing the commitment to equity, accessibility, and nondiscrimination in service delivery.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
M13: Provider selection - § 438.214
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Scoring element **M13.1** required the MCOs to implement written policies and procedures for a network selection and retention process. For two

State Level
MCOs, provider file reviews identified contracts signed after their effective dates, with no policy addressing backdating for continuity of care. One MCO allowed only single case agreements to be backdated and had instances where provider licensure or certification was not verified prior to contract start dates, and no single case agreements were utilized. Another MCO had newly contracted providers whose credentials were not verified before finalizing contracts. ***This scoring element was not met.***
Recommendations: Revise policies to address contract backdating procedures when needed for continuity of care and ensure provider licensure or certification is verified prior to contract finalization. Strengthening oversight and documentation practices will support compliance with network selection and retention requirements **(M13.1)**.
M14: Subcontractual relationships and delegation - § 438.230
Strengths: The MCOs demonstrated compliance by maintaining ultimate responsibility for all delegated activities and subcontractual relationships. Contracts with subcontractors clearly specified delegated functions, reporting obligations, and remedies for non-performance. Subcontractors were required to comply with all applicable Medicaid laws and regulations, and to permit audits and inspections by federal and state entities. The organizations implemented robust oversight mechanisms, including regular monitoring of subcontractor performance, ownership and control disclosures, and data reporting accuracy. These practices ensured that all delegated entities operated in alignment with contractual and regulatory expectations.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
M15: Practice guidelines - § 438.236
Strengths: The MCOs demonstrated compliance by adopting and implementing clinical practice guidelines that were evidence-based, responsive to member needs, and developed in consultation with network providers. These guidelines were regularly reviewed and updated to reflect current standards of care. The organizations ensured that guidelines were disseminated to all relevant providers and made available to enrollees upon request. Utilization management decisions, member education, and service coverage consistently aligned with these guidelines, supporting high-quality and consistent care delivery.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
M16: Health information systems - § 438.242
Requirements related to Health Information Systems are evaluated separately under the ISCA. Results for these requirements can be found in the ISCA section of the report

Compliance with Standards Review - MCO Level Findings

Community Care, Inc.

The following results provide an overview of the compliance review conducted for CCI.

Table 52. CCI Compliance with Standards Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. • The organization demonstrated the ability to ensure coordination and continuity of member care.
Weaknesses/Opportunities for Improvement
• Scoring element **M1.8** required the MCO to maintain complete and current information in the electronic version of the provider directory on the MCO's website. The *Provider Enterprises System (PES) User Guide* is an internal resource MCO staff reference when searching for providers via the MCO's internal database. Through the provider file verification, MetaStar identified several providers not listed in the online directory. CCI provided rationale for situations when providers are not listed in the online directory; however, these reasons were not identified in MCO policies or procedures. This requirement was identified as a recommendation in a previous review. Documents reviewed also did not include a process for ensuring the MCO maintains complete and current information in the electronic provider directory. ***This scoring element was not met.*** • Scoring element **M5.1** required the MCO to ensure coordination of long-term care services with health care services received by the member, as well other services available from natural and community supports. Monitoring results from the MCO's internal file review, as well as MetaStar's care management review show a need for improvement related to follow-up for FC, FCP, and PACE programs. ***This scoring element was not met.*** • Scoring element **M6.5** required the MCP to be based on the comprehensive assessment. IDT staff shall involve the member and other parties in accordance with the member's preference and the parties' ability to contribute to the development of the MCP. Internal monitoring results related to comprehensiveness of MCPs indicated a need for improvement for FC and FCP programs, as did the MetaStar CMR results. ***This scoring element was not met.*** • Scoring element **M9.9** required that members can request electronic materials in paper form without charge, and that the organization has obtained member consent to receive materials electronically. The staff interviews confirmed that this material could be printed and provided to members; however, there was no current written guidance submitted stating that the MCO has a process to obtain member consent to receive material electronically. The most current version of the document titled *Member and Marketing Communication Review and Marketing Process* did not include this requirement. This information was contained in the previous version of this document

MCO Level

that was submitted. It was not clear from the staff interviews that staff were aware of any process for obtaining consent for electronic materials. ***This scoring element was not met.***

- Scoring element **M9.10** required that the MCO has safeguards in place to ensure delivery of electronic materials. The organization's documentation submitted show that members have the ability to opt out of receiving electronic communications and that the MCO ensures member contact information is current, and that materials are sent timely. The was no written guidance submitted stating that the MCO has a process for mailing hard copies when electronic communications are undeliverable. The most current version of the document titled *Member and Marketing Communication Review and Marketing Process* did not include this requirement. This information was contained in the previous version of this document that was submitted. ***This scoring element was not met.***
- Scoring element **M9.11** required that the MCO disseminates copies of needed materials to new members. The organization submitted documentation that the MCO provides copies of the Member Handbook, Provider Network Directories, Self-Directed Support Guidebook, and the PACE Summary of Benefits when applicable. There was no current written guidance submitted stating the MCO supplies FCP members with a copy of the Summary of Benefits. The most current version of the document titled *Member and Marketing Communication Review and Marketing Process* did not include this requirement. This information was contained in the previous version of this document that was submitted. ***This scoring element was not met.***
- Scoring element **M13.1** required the MCO to implement written policies and procedures for a network selection and retention process. The provider file verification identified several provider contracts that were signed after the effective date. MetaStar received two versions of the *Provider Contracting* policy. The most recent version did not reference the process for backdating contracts when there is a need for continuation of services. This requirement was unmet in a previous review. ***This scoring element was not met.***
- Scoring element **M13.11** stated that the MCO shall require co-employment agencies and fiscal employer agents to perform background checks that are substantially similar to the background checks required under Wisconsin Statutes § 50.65 and Wisconsin Administrative Code Chapter DHS 12 on individuals providing service to self-directing members who have, or are expected to have, regular, direct contact with the member. Monitoring of caregiver background checks for SDS staff was evidenced via a tracking spreadsheet. Regular contact with fiscal agents to review concerns was also evidenced. MetaStar received two version of the *Background Check Compliance Process*. The most recent version did reference the SDS background check audit process. However, the policy was updated after the review period and the prior version did not include this information. This requirement was identified as a recommendation in a previous review. ***This scoring element was not met.***
- Scoring element M14.5 required the MCO to respond to SODs by taking reasonable and prudent actions to assure member health and safety. Tracking of individual SODs was confirmed through the

MCO Level
SOD Weekly Report which outlined recommended follow-up actions such as contact with the provider and/or site visits by MCO staff. Follow-up activities were evidenced through documents reviewed as well as the provider file verification. The *Provider Management SOD Process* provides guidance for the identification and monitoring of SODs by the MCO. However, policies did not outline the process and expectations for SOD follow-up activities. ***This scoring element was not met.***
Recommendations
• Update internal policies to include the process for maintaining a complete and current electronic version of the provider network directory. Provide clarity when a contracted provider is not included in the external provider directory **(M1.8)**. • Focus efforts on improving documentation of follow-up activities and continue current monitoring and feedback practices in all programs **(M5.1)**. • Focus efforts on improving the comprehensiveness of member-centered plans, and continue current monitoring and feedback practices in FC and FCP programs **(M6.5)**. • Develop and implement a consent form for members to receive electronic materials that includes options for all member materials. Update policy documents and staff training to include guidance on the process to obtain member consent to receive electronic materials **(M9.9)**. • Update policy documents to include written guidance for a process to mail hard copies of materials when electronic communications are undeliverable **(M9.10)**. • Update policy documents to include written guidance that the Summary of Benefits document is provided to FCP members upon enrollment **(M9.11)**. • Update internal policies to include the credentialing process when there is a need for continuation of services **(M13.1)**. • Update internal policies to include processes for monitoring background checks for self-direct support employees **(M13.11)**. • Update internal policies to align with provider quality monitoring processes related to follow-up actions taken when ensuring quality of Division of Quality Assurance regulated providers **(M14.5)**.

Independent Care Health Plan

The following results provide an overview of the compliance review conducted for *i*Care.

Table 53. *i*Care Compliance with Standards Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected.

MCO Level
• The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. • The organization demonstrated the ability to ensure coordination and continuity of member care.
Weaknesses/Opportunities for Improvement
• Scoring element **M1.8** required the MCO to maintain complete and current information in the electronic version of the provider directory on the MCO's website. Through the provider file verification, MetaStar identified several providers not listed in the online directory. Additionally, in FY 22-23 MetaStar recommended that the FC program include timeframes for provider directory updates to ensure continued complete and current provider directory information. The FC *Provider Development Policy and Procedure* indicates that any updates will populate to the online directory within 24 hours of entry into the provider management system. However, it does not identify a timeframe for when the provider management system should be updated after the MCO is notified of a change for FC providers. ***This scoring element was not met.*** • Scoring element **M5.1** required the MCO to ensure coordination of long-term care services with health care services received by the member, as well other services available from natural and community supports. Monitoring results from the MCO's internal file review, as well as MetaStar's CMR, show a need for improvement related to follow-up for FC and FCP programs. ***This scoring element was not met.*** • Scoring element **M6.5** required the MCP to be based on the comprehensive assessment. IDT staff shall involve the member and other parties in accordance with the member's preference and the parties' ability to contribute to the development of the MCP. Internal monitoring results related to comprehensiveness of MCPs indicated a need for improvement for FC and FCP, as did the MetaStar CMR results. ***This scoring element was not met.*** • Scoring element **M9.9** required that members can request electronic materials in paper form without charge, and the organization is to provide these materials to members within five business days. The staff interviews confirmed that if requested, this material could be printed and provided to the member. There was no written guidance submitted stating these materials need to be provided within five business days for the FCP program. It was not clear from the staff interviews that FCP staff were aware of this requirement. This requirement was identified as a recommendation in previous reviews for FCP. ***This scoring element was not met.*** • Scoring element **M13.1** required the MCO to implement written policies and procedures for a network selection and retention process. The provider file review identified several newly contracted providers whose licensure or certification was not verified prior to contract finalization. ***This scoring element was not met.***
Recommendations

MCO Level
• Update internal policies in the FC program to ensure continued complete and current provider directory information. Policies should include timeframes for entering updated information into the provider management system after being notified of a change **(M1.8).** • Focus efforts on improving documentation of follow-up activities and continue current monitoring and feedback practices in both programs **(M5.1)**. • Focus efforts on improving the comprehensiveness of MCPs, and continue current monitoring and feedback practices in both programs **(M6.5).** • Update policy documents for FCP to include the required timeframe for providing electronic material to members in a paper format **(M9.9).** • Enact practices to ensure licensures and certifications are verified prior to the provider contract start date **(M13.1).**

Lakeland Care, Inc.

The following results provide an overview of the compliance review conducted for LCI.

Table 54. LCI Compliance with Standards Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected. • The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers.
Weaknesses/Opportunities for Improvement
• Scoring element **M5.1** required the MCO to ensure coordination of long-term care services with health care services received by the member, as well other services available from natural and community supports. Monitoring results from the MCO's internal file review, as well as MetaStar's CMR show a need for improvement related to follow-up. ***This scoring element was not met.*** • Scoring element **M6.10** required a fully developed MCP to be completed and signed by the member or the member's legal decision maker within 60 calendar days of the enrollment date. Internal monitoring results related to completed and signed MCPs indicated a need for improvement, as did the MetaStar CMR results. ***This scoring element was not met.*** • Scoring element **M7.4** required the MCO to ensure continuity of services for members during the disenrollment process. The MCO is required to assist members whose enrollment ceases for any reason in obtaining transitional care. The information was found in the MCO's *MCO Requested Disenrollment Procedure*, but was not found in the MCO's *Enrollment & Disenrollment Policy and Procedure* which includes the other types of disenrollment. This scoring element was also not met in the previous review. ***This scoring element was not met.***

MCO Level
• Scoring element **M11.1** required the MCO to have written policies and procedures related to member rights, including the right to be free from any form of restraint or seclusion. The scoring element includes a review of the MCO's restrictive measures log to ensure timely renewal of restrictive measures applications. The MCO's policy and procedure documents have procedures in place for submitting timely renewal applications to DHS, and practice requirements if a restrictive measure is expired. Staff participating in the IDT interviews described knowledge and understanding of restrictive measures. The review of the restrictive measures log demonstrated that there was an application renewal that was not sent to DHS timely. The MCO did offer some further information regarding the extenuating circumstances of this specific case; however, restrictive measure renewal applications are required to be sent to DHS 45 days prior to their expiration date. ***This scoring element was not met.***
• Scoring element **M13.1** required the MCO to implement written policies and procedures for a network selection and retention process. The provider file verification identified several provider contracts that were signed after the effective date. The MCO indicated that this occurs when members transfer to the MCO with a provider in place and are part of continuity of care requirements. While the MCO is appropriately following continuity of care requirements, policies did not reference the process for backdating contracts where there is a need for continuation of services. ***This scoring element was not met.***
• Scoring element **M14.1** required the MCO and the subcontractor or provider to have a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor. The provider file verification identified two providers with MOUs. An MOU template was also provided as a part of the document review. The organization explained that the MOU is an outdated contract type which is no longer used. If an existing MOU needs to be changed, it is transitioned to a contract type referenced in the *Contract Determination Policy & Procedure;* existing MOUs are not terminated. However, the providers identified in the provider file verification with MOUs in place both had new locations added to the MOU during the review period. There was no evidence that the MOUs were transitioned to a different contract type. Additionally, the *Contract Determination Policy & Procedure* does not outline the process for transitioning an MOU to a different contract type. ***This scoring element was not met.***
• Scoring element **M15.4** required the MCO to disseminate and make clinical practice guidelines available to all affected providers for whom the guidelines apply. Providers access the guidelines through the provider portal of the MCO's website. The MCO submitted a screen shot from the provider portal listing four practice guidelines. These guidelines were not the most current versions compared to the guidelines in the *LCI Clinical Practice and Health Promotion Guidelines* and did not include the MCO's blood pressure monitoring guideline. This scoring element was also not met in the previous review. ***This scoring element was not met.***
Recommendations

MCO Level
• Focus efforts on improving documentation of follow-up activities and continue current monitoring and feedback practices **(M5.1)**. • Focus efforts on improving the timely completion and signing of initial MCPs **(M6.10)**. • Ensure all disenrollment policies include the requirement to assist members in obtaining transitional care when enrollment ceases for any reason **(M7.4)**. • Make efforts to ensure restrictive measure applications are submitted timely to DHS **(M11.1)**. • Update internal policies to include the credentialing process when there is a need for continuation of services **(M13.1)**. • Amend internal policies to include the process for transitioning memorandums of understanding to a different contract type. **(M14.1)**. • Update the process to disseminate practice guidelines to providers to ensure all current guidelines are available to providers (**M15.4)**.

My Choice Wisconsin

The following results provide an overview of the compliance review conducted for MCW.

Table 55. MCW Compliance with Standards Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• The organization has strong systems in place to help members understand their rights as well as ensuring those rights are protected. • The organization demonstrated the ability to ensure availability of accessible, culturally competent services through a network of qualified service providers. • The organization demonstrated the ability to ensure coordination and continuity of member care.
Weaknesses/Opportunities for Improvement
• Scoring element **M5.1** required the MCO to ensure coordination of long-term care services with health care services received by the member, as well other services available from natural and community supports. Monitoring results from the MCO's internal file review, as well as MetaStar's CMR, show a need for improvement related to follow-up for the FC and FCP programs. ***This scoring element was not met.*** • Scoring element **M6.10** required a fully developed MCP to be completed and signed by the member or the member's legal decision maker within 60 calendar days of the enrollment date. Internal monitoring results related to completed and signed MCPs indicated a need for improvement for the FC and FCP programs, as did the MetaStar CMR results. ***This scoring element was not met.*** • Scoring element **M13.1** required the MCO to implement written policies and procedures for network selection and retention process. The *Provider Network Oversight* procedure noted that it is

MCO Level
the MCO's policy to verify provider credentials, including licensure or certification, prior to entering into a contract. The *Member Enrolled in Place* process includes the ability to backdate single case agreements as a mechanism to support continuity of care. Document request responses from the organization confirmed that contract start dates are not backdated, as credentialing must be completed before contracting with providers. No single case agreements were included in the verification. The provider file verification identified several providers whose license or certification was not verified prior to the contract start date for new providers, or prior to the review period for existing providers. ***This scoring element was not met.***
• Scoring element **M13.6** required that providers utilized by the MCO not be excluded from participation in federal health care programs. The provider file verification identified several providers whose debarment check was not completed prior to the review period. The MCO submitted monthly LEIE, OIG exclusions, and OIG reinstatement lists. Documents did not confirm that debarment checks were completed for sampled providers prior to the review period. ***This scoring element was not met.***
• Scoring element **M13.9** required that the MCO ensure providers perform background checks in compliance with Wisconsin Statutes § 50.65 and Wisconsin Administrative Code Chapter DHS 12. The *My Choice Wisconsin Quality Management Work Plan Evaluation* noted that in April 2024 the prior caregiver background check audit process ended and oversight was transitioned to the credentialing department. In November 2024, an attestation validation process was implemented, which includes an audit of caregiver background check results. The *Caregiver Background Check Attestation Validation Audit Results* confirmed monitoring of attestation validations completed in November and December 2024. However, caregiver background check monitoring was not evident prior to November 2024. ***This scoring element was not met.***
Recommendations
• Focus efforts on improving timely follow-up for effectiveness of services and continue current monitoring and feedback practices in both programs **(M5.1)**.
• Focus efforts on improving the timely completion and signing of initial MCPs in both programs **(M6.10)**.
• Enact practices to ensure licenses and certifications are verified prior to the contract start date **(M13.1)**.
• Ensure debarment checks are completed prior to the contract start date **(M13.6)**.
• Complete caregiver background check monitoring of providers at consistent and regular intervals throughout the year to ensure providers are complying with attestation requirements **(M13.9)**.

Compliance with Standards Review- Progress on Prior Recommendations

MetaStar assessed the degree that the organizations effectively addressed recommendations for quality improvement made during the previous review. The following rating scale was applied.

Table 56. Degree to Which the Organizations Addressed the Recommendations

Degree	Description
High	The organizations addressed all recommendations.
Medium	The organization addressed half of the recommendations, but not all.
Low	The organization addressed less than half of the recommendations.
N/A	No recommendations received.

The following table identifies the state-level recommendations made in the prior review of the standards, the actions taken to address the recommendations, and the degree to which the organizations addressed the recommendations. If no actions were taken, or were insufficient to address the recommendation, they will not be listed in the corresponding column.

Table 57. State-Level Progress on Prior Recommendations

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
– Ensure organizations comply with written policies for the selection and retention of providers **(M13.1)**. – Continue efforts to ensure requirements related to care management are fully implemented **(M5.1, M6.5, M6.10)**.	– No progress was identified.	Low

The following table identifies the recommendations made by the EQRO in the prior review of the standards, the actions taken by the MCOs to address the recommendations, and the degree to which the MCOs addressed the recommendations. If no actions were taken, or were insufficient to address the recommendation, they will not be listed in the corresponding column.

Table 58. MCO-Level Progress

MCO	Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCI	– Update internal procedures to provide clarity when a contracted provider is not included in the external provider directory and include how that information is available to the organization's IDT staff through the internal provider database **(M1.8)**. – Improve timeliness of follow-up for member needs and services in all programs, especially for medical appointments **(M5.1)**. – Continue to focus efforts on improving comprehensiveness of assessments and MCPs in the FC and FCP programs **(M6.5)**. – Develop and implement a consent form for members to receive electronic materials for all programs that includes options for all member materials (**M9.9)**. – Update internal policies and procedures with additional guidance to include the credentialing process for when there is a need for continuation of services, specifically related to new providers **(M13.1)**. – Align relevant documents and update internal policies and procedures pertaining to caregiver background checks of MCO staff **(M13.7).**	– The organization aligned relevant documents and updated internal policies and procedures pertaining to caregiver background checks of MCO staff **(M13.7)**.	Low
*i*Care	– Continue efforts to ensure timely follow-up for effectiveness of services in both programs **(M5.1)**. – Continue efforts to improve the comprehensiveness of assessments	– The FC program improved comprehensiveness of assessments **(M6.1).**	Medium

MCO	Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	through ensuring assessment of member educational experiences and preferences in the FC program **(M6.1)**. – Focus efforts on improving the comprehensiveness and timeliness of MCPs in both programs **(M6.5)**. – Implement practices to obtain signatures from all essential providers on an annual basis in the FCP program **(M6.10)**. – Update written guidance and educate all providers on the specific reasons providers may advocate for FC members **(M9.12)**. – Review and update organizational processes to ensure that restrictive measure applications are submitted timely to DHS and that renewals are approved prior to expiration in the FC program **(M11.1)**. – Review and align recredentialing processes and practices to ensure consistency within the organization and with providers for FC **(M13.1)**. – Update internal procedures with additional debarment guidance, specifically related to new providers and providers using legal names and business names, and have a plan in place for debarment monitoring if potential barriers arise, such as staff changes in the FC program **(M13.6)**. – Review and update policies and procedures pertaining to caregiver background check monitoring to ensure there is consistency within the organization and with	– The FCP program improved the timely completion and signing of initial MCPs **(M6.10).** – The organization submitted restrictive measure applications timely, and has taken steps to ensure renewals are approved prior to expiration **(M11.1).** – The organization updated internal procedures with additional debarment guidance, specifically related to new providers and providers using legal names and business names **(M13.6).** – The organization updated policies and procedures pertaining to caregiver background check monitoring to ensure there is consistency within the organization and with providers **(M13.9).**	

MCO	Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	providers, and ensure representative samples sizes when conducting *Best Practice Reviews* in the FC program **(M13.9)**.		
LCI	– Continue current monitoring and feedback practices and training efforts to ensure follow-up to member needs and services **(M5.1)**. – Focus efforts on improving the comprehensiveness of MCPs **(M6.5)**. – Ensure all disenrollment policies include the requirement to assist members whose enrollment ceases for any reason in obtaining transitional care **(M7.4)**. – 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 **(M13.1)**. – Revise the process to disseminate practice guidelines to providers for consistency **(M15.4)**.	- The organization focused efforts improving the comprehensiveness of MCPs **(M5.1)**. - The organization developed and implemented a procedure for verifying licensure/certification prior to contracting, and for ongoing monitoring of providers with individually licensed or certified practitioners **(M13.1)**.	Low
MCW	– Focus efforts to ensure timely follow-up for effectiveness of services in both programs, especially needs related to members' medical care **(M5.1)**. – Continue efforts to improve the comprehensiveness of MCPs in the FC program **(M6.5)**.	– The organization focused efforts improving the comprehensiveness of MCPs in the FC program. **(M6.5)**	Medium

Protocol 4: Validation of Network Adequacy

The validation of each MCOs' and PIHPs' network adequacy is a mandatory EQR activity identified in 42 CFR § 438.358. Review activities are conducted according to federal protocol. See Appendix 1 for more information about the NAV review methodology.

Network adequacy standards are included by reference in the 2024 DHS-MCO contracts for FC, FCP, and 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

Providers of 1915(c) HCBS waiver services and supports, or FC long-term state plan services and supports are included in this report.

The following tables identify the network adequacy standards established by DHS for FC, FCP, and PACE.

Table 59. NAV: Provider to Member Ratios

Network Adequacy Indicator(s)	Applicable Provider Types	Applicable Regions
75 Members to 1 Provider	- Adult Residential Care 1 – 2 Bed and 3 – 4 Bed	Statewide
150 Members to 1 Provider	- Mental Health Services - Mental Health Day Treatment - Transportation	Statewide
200 Members to 1 Provider	- Adult Residential Care - Community Based Residential Facility - AODA Services - AODA Day Treatment - Daily Living Skills Training - Occupational Therapy - Physical Therapy - Respiratory Care - Speech and Language Pathology Services	Statewide
250 Members to 1 Provider	- Home Health Services - Prevocational Services - Supported Employment – Individual and Group	Statewide
300 Members to 1 Provider	- Adult Residential Care – Residential Care Apartment Complex	Statewide

Network Adequacy Indicator(s)	Applicable Provider Types	Applicable Regions
	- Counseling and Therapeutic Resources - Daily Habilitation Services - Supportive Home Care	
350 Members to 1 Provider	- Adult Day Care Services - Community Support Program - Nursing Home Stays	Statewide
400 Members to 1 Provider	- Respite	Statewide
775 Members to 1 Provider	- Nursing - Personal Care - Self-Directed Personal Care - Skilled Nursing Services	Statewide
900 Members to 1 Provider	- Consumer Directed Supports (Self-Directed Supports) Broker - Financial Management Services	Statewide
1,200 Members to 1 Provider	- Home-Delivered Meals	Statewide

Table 60. NAV: Wait Time to Receive Services

Network Adequacy Indicator(s)	Applicable Provider Types	Applicable Regions
For general equipment or supplies, no more than 30 business days from the time of service order. For highly specialized equipment and supplies, no more than 120 business days from the time of service order.	- Adaptive Aid - Assistive Technology and Communication aids - Specialized Medical Equipment and Supplies - Durable Medical Equipment - Disposable Medical Supplies	Statewide
No more than 30 business days from time of service order.	- Personal Emergency Response Systems Services. - Vocational Futures Planning and Support	Statewide
No more than 60 business days from time of service approval.	- Consumer Education and Training - Home Modifications - Housing Counseling - Relocation Services - Training Services for Unpaid Caregivers	Statewide

The table below identifies the data sources utilized to validate the network adequacy standards and the corresponding timeframe for the data.

Table 61. Data Sources

Network Adequacy Standard	Data Source(s)	Data Timeframes
Provider to Member Ratios	Provider and Member data extracts submitted by the MCO	October 1, 2024
Wait Time to Receive Services	Member authorizations submitted by the MCO	January 1, 2024 – October 31, 2024

Additional evaluations of the MCOs' network adequacy were performed to provide additional insight into the organization's network and are listed in Table 4 below. These analyses do not have defined standards and will not have a validation rating.

Table 62. Additional Network Adequacy Analysis

Network Adequacy Analysis	Applicable Provider Types	Applicable Regions	Data Sources
Grievance and Appeal Review	All Providers	Statewide	CY 2024 MCO level Grievance and Appeals logs submitted by the MCO and CY 2024 state level Grievance and Appeals logs obtained from MetaStar
Provider Directory to Provider Extract Match	See Table 1 for Provider Service Types included in this analysis	Statewide	Provider Directory and Provider data extracts submitted by the MCO from October 1, 2024

Validation of Network Adequacy – Results

This report addresses the network adequacy requirements for the review period of January 1, 2024 – December 31, 2024, with validations conducted FY 24-25. Network adequacy is reported in terms of a percentage score and a validation rating identified in the table below. See Appendix 1 for more information about the scoring methodology.

Table 63. NAV Scoring Legend

Percentage Score	Compliance Rating
90.0% – 100.0%	High Confidence
50.0% – 89.9%	Moderate Confidence
10.0% – 49.9%	Low Confidence

Percentage Score	Compliance Rating
Below 10.0%	No Confidence

Validation of Network Adequacy Results: Member to Provider Ratios

The provider network was analyzed using provider and member data files (extracts) submitted by each MCO, which included detailed information on contracted providers and enrolled members. Members were excluded from the analysis if they resided outside of the MCO and program's geographic service area. Maps of each region can be found on the DHS Family Care website and Partnership/PACE website.

Family Care Geographic Service Region Map (wisconsin.gov)

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

The validation scores and ratings for the member to provider ratio indicator for each program are identified in the table below.

Table 64. NAV Results: Member to Provider Ratio

Program	Validation Score	Validation Rating
FC	94.2%	High Confidence
FCP	98.4%	High Confidence
PACE	100.0%	High Confidence

The table below shows the percentage of counties across all applicable service types that met the member to provider ratio in each program in the current and prior review. Please see Appendix C for the list of service types and member to provider ratios.

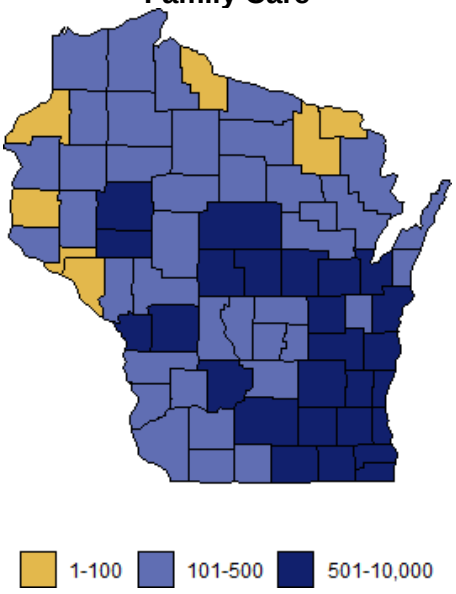
Table 65. NAV Member to Provider Ratio Met by County

Program	CY 2024 Percent of Counties	CY 2025 Percent of Counties
FC	94.5%	94.2%
FCP	98.4%	98.4%
PACE	99.2%	100.0%

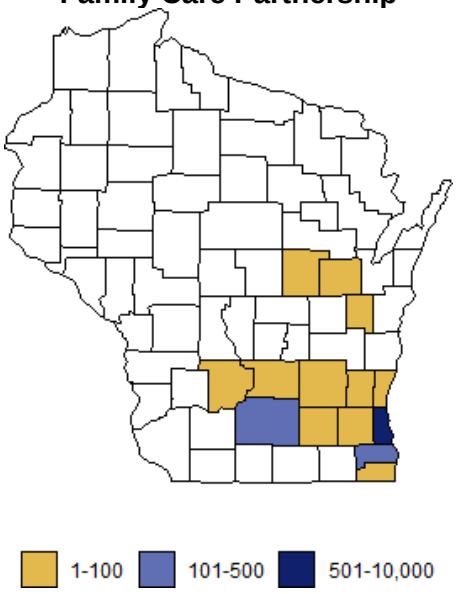
The following maps display the distribution of members by program as well as the top service types that did not meet network adequacy standards.

Figure 1. MCO Members by County

Family Care



Family Care Partnership



PACE

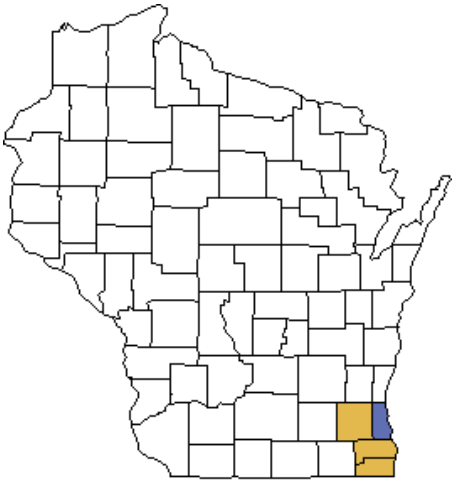
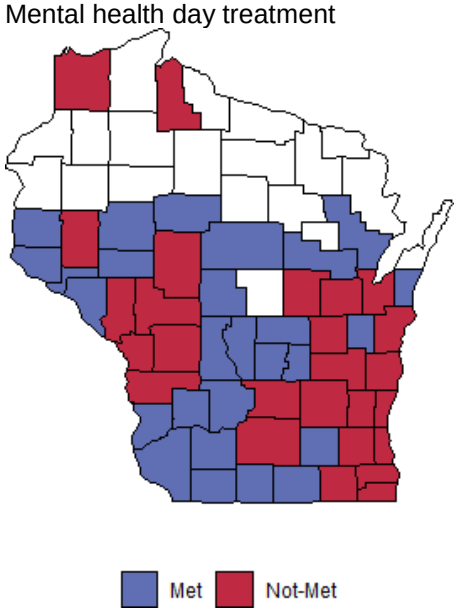


Figure 2. Top Service Types Not Meeting Targets by Program

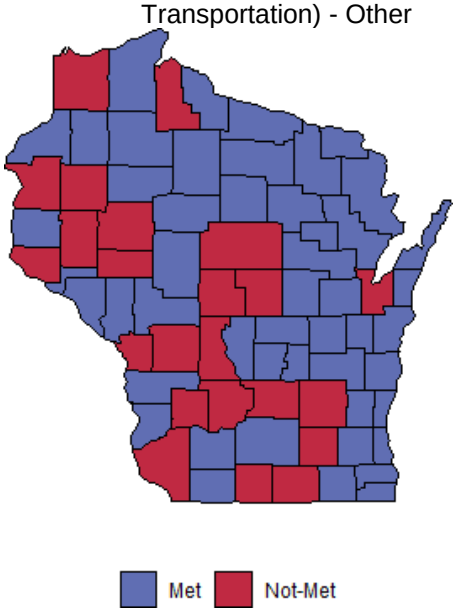
Family Care

1. Mental health day treatment



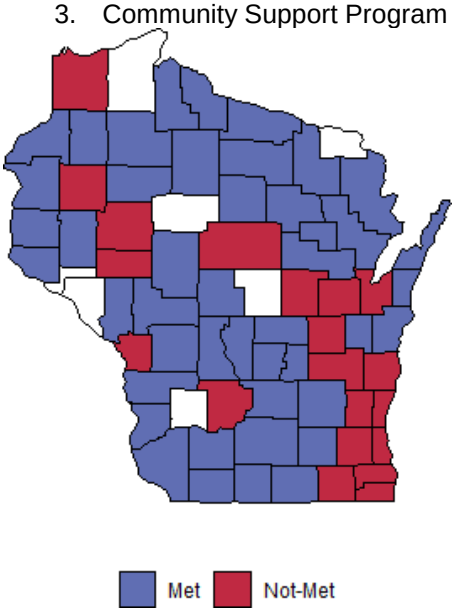
Not Met Count: 26

2. Transportation (Specialized Transportation) - Other



Not Met Count: 23

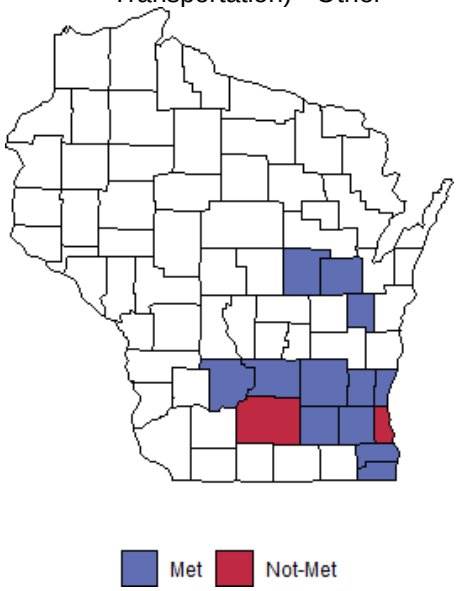
3. Community Support Program



Not Met Count: 20

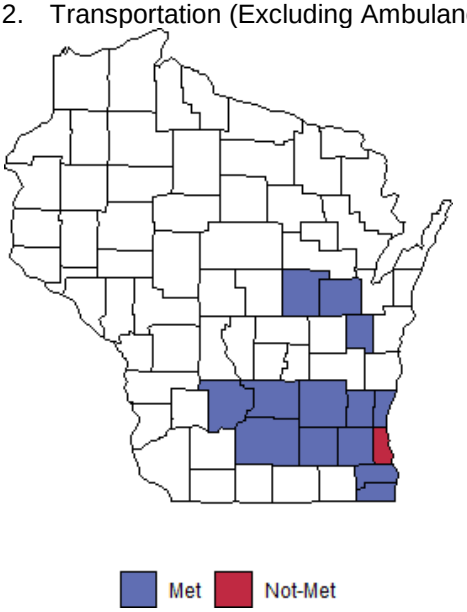
Family Care Partnership

1. Transportation (Specialized Transportation) - Other



Not Met Count: 2

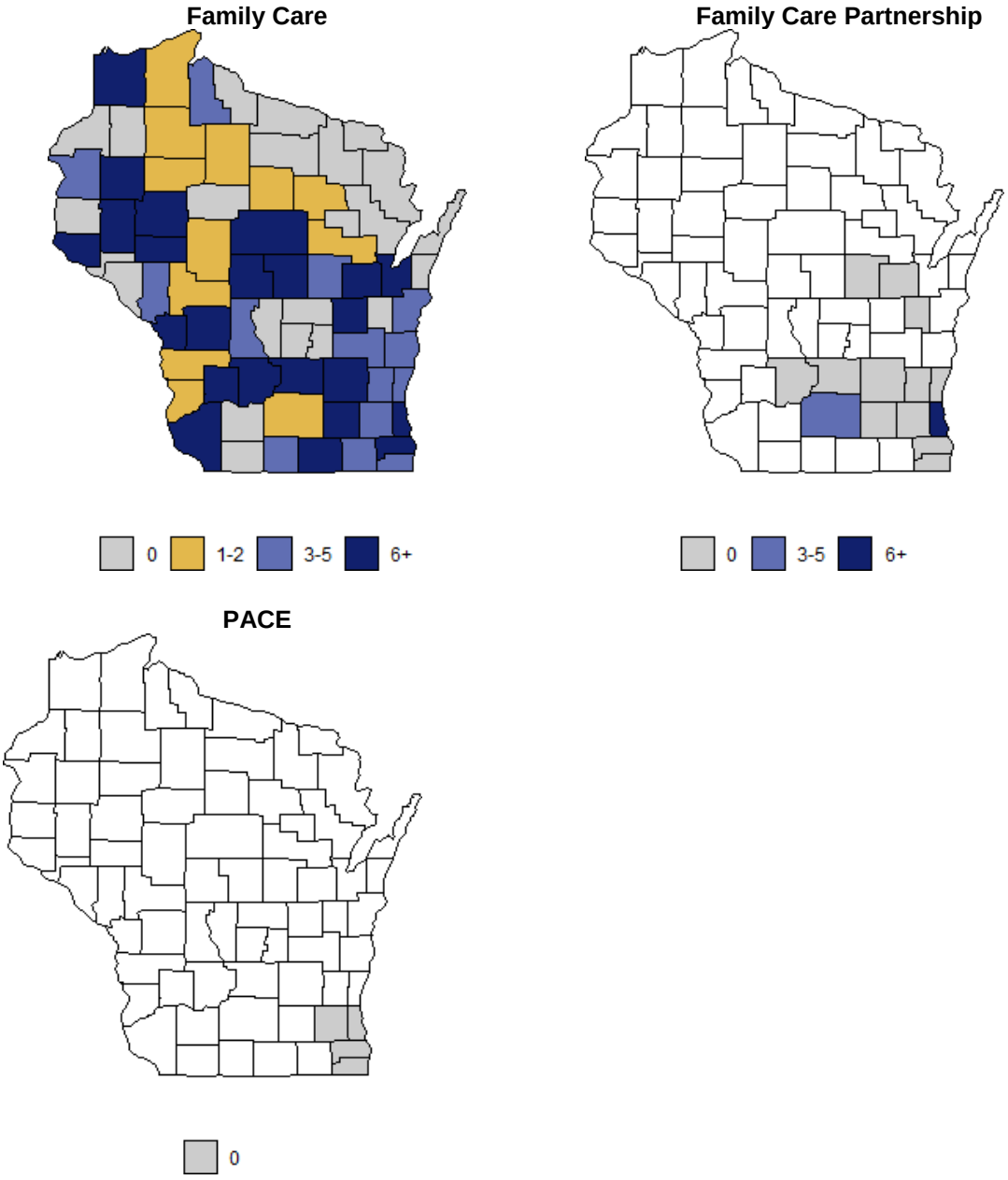
2. Transportation (Excluding Ambulance)



Not Met Count: 1

Note, there were no Not Met counties for PACE.

Figure 3. Number of Service Types Not Meeting Target by County



Validation of Network Adequacy Results: Wait Time to Receive Services

Wait times for receiving services were assessed by comparing service authorizations from the MCO with paid claims data obtained from DHS. A sample of services authorizations was generated for each MCO and program. The authorizations were compared to the paid claims data to determine if wait time standards were achieved.

The validation scores and ratings for the wait time indicator for each program are identified in the table below.

Table 66. NAV Results: Wait Time to Receive Services

Program	Validation Score	Validation Rating
FC	82.0%	Moderate Confidence
FCP	49.4%	Low Confidence
PACE	86.7%	Moderate Confidence

Each applicable provider type is subject to different wait time standards. The tables below present the percentage of services, categorized by service or provider type, that met the applicable wait time standards within each program.

The table below shows the percentage of provider types that met the standard wait time: no more than 30 business days from the date of the service order. For highly specialized equipment and supplies, the standard is no more than 120 business days from the service order date.

Table 67. NAV Wait Time Analysis: 30 Business Day or 120 Business Days

Provider Type	FC Percent Met	FCP Percent Met	PACE Percent Met
Adaptive Aid	77.8%	50.0%	100.0%
Assistive Technology and Communication aids	78.8%	75.0%	100.0%
Specialized Medical Equipment and Supplies	86.9%	75.0%	100.0%
Durable Medical Equipment	75.6%	68.8%	69.2%
Disposable Medical Supplies	81.8%	91.7%	100.0%

The table below shows the percentage of provider types that met the standard wait time: no more than 30 business days from the date of the service order.

Table 68. NAV Wait Time Analysis: 30 Business Days

Provider Type	FC Percent Met	FCP Percent Met	PACE Percent Met
Personal Emergency Response System Services	81.5%	11.1%	100.0%
Vocational Futures Planning and Support	20.0%	100.0%	N/A

The table below shows the percentage of provider types that met the standard wait time: No more than 60 business days from time of service approval.

Table 69. NAV Wait Time Analysis: 60 Business Days

Provider Type	FC Percent Met	FCP Percent Met	PACE Percent Met
Consumer Education and Training	87.5%	100.0%	N/A
Home Modifications	97.6%	75.0%	100.0%
Housing Counseling	100.0%	50.0%	N/A
Relocation Services	95.0%	92.3%	100.0%
Training Services for Unpaid Caregivers	100.0%	100.0%	N/A

Additional Network Adequacy Analysis

Findings from the additional evaluations of the organization's network adequacy are listed in the table below. These analyses do not have defined standards and do not receive a validation rating.

Table 70. Additional Network Adequacy Analysis Results: Provider Directory to Provider Extract Match

Program	Results
FC	89.0%
FCP	81.2%
PACE	97.7%

Grievance and Appeal Review

Grievances and appeals filed in CY 2024 with the MCO as well as grievances and appeals filed with DHS and DHA were reviewed to identify any concerns related to network adequacy, including potential service gaps. This analysis helps uncover patterns such as delays in accessing services, lack of available providers in specific specialties or geographic service areas, and repeated member compliant about provider availability.

The table below documents the percent of grievances or appeals, identified as issues, related to access, availability of services, and other network related issues. Common access issues included member grievances about delays in residential placement, SHC, and transportation services. Additionally, communication challenges with the interdisciplinary team frequently served as a barrier to timely access.

Table 71. Network Adequacy Grievance and Appeal Frequency

Issue Type	FC *(1,075 Total Issues)* Percent of Issues	FCP *(105 Total Issues)* Percent of Issues	PACE *(23 Total Issues)* Percent of Issues
Access Issues	4.4%	7.6%	17.4%
Availability of Services	0.8%	0.0%	0.0%
Other	0.0%	0.0%	0.0%

Provider Directory

The table below shows the percentage of locations that matched between the MCO's provider extract and provider directory in each program.

Table 72. Provider Directory Location Match

Program	CY 2024 Percent of Locations	CY 2025 Percent of Locations
FC	92.7%	89.0%
FCP	98.4%	81.2%
PACE	99.2%	97.7%

Validation of Network Adequacy - State Level Findings

The table below identifies strengths, weaknesses/opportunities for improvement, and recommendations for each standard reviewed. Strengths are given for standards that scored at or above 90 percent. Weaknesses, or opportunities for improvement, are included for any standard that is below 90 percent, and any scoring element that was not met. Additional opportunities for improvement may be included for elements that are minimally compliant. Recommendations are provided for all identified weaknesses and opportunities for improvement.

Table 73. NAV Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Assessment of Network Adequacy Data, Methods, and Results
Reliability and Validity of Network Adequacy Data
Strengths: All MCOs have a strong system that is maintained and updated by a stable and experienced information system department. All MCOs provided evidence of robust, ongoing training

Assessment of Network Adequacy Data, Methods, and Results
programs to ensure all Medicaid data is processed accurately and within the expected timeframes. All MCO security systems met or exceeded most industry standards, ensuring consistent system and data availability.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Network Adequacy Assessment Methods
Strengths: All MCO processes and systems for collecting and maintaining administrative data and enrollment information ensure accurate encounter data is provided to the state.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Network Adequacy Results
Strengths: **Member to Provider Ratio:** All MCO data was submitted accurately and reflects the number of providers available to serve enrolled members, and the ratios met or exceeded established standards. The MCOs have sufficient numbers of providers relative to their member populations, and the provider networks are adequately distributed to meet member needs. Additionally, the data used to calculate the ratios is complete, current, and free from significant errors or inconsistencies. **Wait Time to Receive Services:** FC demonstrated strong practices in meeting wait-time standards for home modifications, housing counseling, relocation services and training services for unpaid caregivers. Strengths were noted for FCP related to DMS, vocational futures planning and support, consumer education and training, relocation services, and training services for unpaid caregivers. PACE demonstrated strengths with wait-time standards for adaptive aids, assistive technology and communication aids, specialized medical equipment and supplies, DMS, PERS, home modifications, and relocation services.
Weaknesses/Opportunities for Improvement: **Member to Provider Ratio:** The service types mental health day treatment, transportation (specialized transportation) – other, and CSP did not meet the network adequacy standards in several counties for FC. **Wait Time to Receive Services:** FC MCOs did not consistently meet wait-time standards for adaptive aids, assistive technology and communication aids, DME, DMS, PERS, and vocational futures planning and support. The FCP program had opportunities for improvement related to adaptive aids, assistive technology and communication aids, specialized medical equipment and supplies, DME, PERS, home modifications, and housing counseling. PACE did not consistently meet wait-time standards for DME.
Recommendations:

Assessment of Network Adequacy Data, Methods, and Results
Member to Provider Ratio: Improve the network of providers in the service types that did not meet the member to provider ratio standard in all counties. **Wait Time to Receive Services:** Decrease wait times for those provider types that did not meet the wait time standards.

Validation of Network Adequacy – Managed Care Organization Level Findings

Community Care, Inc.

The following results provide an overview of the validation conducted for CCI.

Table 74. CCI NAV Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
Member to Provider Ratio: CCI's data submitted accurately reflects the number of providers available to serve enrolled members, and the ratios meet or exceed established standards. The MCO has a sufficient number of providers relative to its member population, and the provider network is adequacy distributed to meet member needs. Additionally, the data used to calculate the ratios is completed, current, and free from significant errors or inconsistencies. **Wait Time to Receive Services:** CCI FC's wait time validation confirmed strengths with established timelines for assistive technology, specialized medical equipment and supplies, DME, DMS, home modifications and relocation services. CCI's FCP program demonstrated strengths with established timelines for DMS, PERS, consumer education, and home modifications. Additional strengths were identified for CCI PACE for adaptive aids, assistive technology, specialized medical equipment and supplies, DMS, PERS, home modifications, and relocation services.
Weaknesses/Opportunities for Improvement
Member to Provider Ratio: Although the overall member-to-provider ratio was above 90 percent for FC, mental health day treatment, CSP, and home-delivered meals did not meet the network adequacy standards in several counties. **Wait Time to Receive Services:** Opportunities to improve timely access were identified in the areas of adaptive aids, PERS, and consumer education for FC; adaptive aids, assistive technology, and DME for FCP; and DME for PACE.
Recommendations
Member to Provider Ratio: Improve the network of providers in the service types that did not meet the member to provider ratio standard in all counties. **Wait Time to Receive Services:** Decrease wait times for those provider types that did not meet the wait time standards.

Independent Care Health Plan

The following results provide an overview of the validation conducted for *i*Care.

Table 75. *i*Care NAV Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
Member to Provider Ratio: iCare's FC and FCP data submitted accurately reflects the number of providers available to serve enrolled members, and the ratios meet or exceed established standards. The MCO has a sufficient number of providers relative to its member population, and the provider network is adequately distributed to meet member needs. Additionally, the data used to calculate the ratios is complete, current, and free from significant errors or inconsistencies. **Wait Time to Receive Services:** *i*Care's FC wait time validation confirmed strengths with established timelines for adaptive aids, specialized medical equipment and supplies, PERS, consumer education, home modifications, housing counseling, and relocation services. The FCP program showed strengths related to vocational futures and planning supports.
Weaknesses/Opportunities for Improvement
Member to Provider Ratio: FC: Although the overall member to provider ratio was above 90 percent for FC, transportation (specialized transportation), respiratory care, and mental health day treatment service types did not meet the network adequacy standards in several counties. FCP: Although the overall member to provider ratio was above 90 percent for FCP, transportation (specialized transportation) and transportation (excluding ambulance) service types did not meet the network adequacy standards in several counties. **Wait Time to Receive Services:** Opportunities to improve timely access were identified for FC and FCP related to DME. FC had additional opportunities in the areas of assistive technology and vocational futures planning and supports. FCP had additional opportunities with adaptive aids, specialized medical equipment and supplies, DMS, PERS, home modifications, housing counseling, and relocation services.
Recommendations
Member to Provider Ratio: Improve the network of providers in the service types that did not meet the member to provider ratio standards in all counties for both programs. **Wait Time to Receive Services:** Decrease wait times for those provider types that did not meet the wait time standards.

Lakeland Care, Inc.

The following results provide an overview of the validation conducted for LCI.

Table 76. LCI NAV Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
Member to Provider Ratio: LCI's data submitted accurately reflects the number of providers available to serve enrolled members, and the ratios meet or exceed established standards. The MCO has a sufficient number of providers relative to its member population, and the provider network is adequacy distributed to meet member needs. Additionally, the data used to calculate the ratios is completed, current, and free from significant errors or inconsistencies. **Wait Time to Receive Services:** LCI's wait time validation confirmed compliance with established timelines for provider types with a 60-business-day standard.
Weaknesses/Opportunities for Improvement
Member to Provider Ratio: Although the overall member to provider ratio was above 90 percent, mental health day treatment, SHC - moving services, and CSP service types did not meet the network adequacy standards in several counties. **Wait Time to Receive Services:** Opportunities for improvement were identified across all provider types with the service standards of 30 business days or 120 business days for highly specialized services. In many cases, the MCO did not provide evidence of a service start date.
Recommendations
Member to Provider Ratio: Improve the network of providers in the service types that did not meet the member to provider ratio standard in all counties for mental health day treatment, SHC - moving services, and CSP service types. **Wait Time to Receive Services:** Decrease wait times for those provider types that did not meet the wait time standards.

My Choice Wisconsin

The following results provide an overview of the validation conducted for MCW.

Table 77. MCW NAV Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
Member to Provider Ratio: MCW's data submitted accurately reflects the number of providers available to serve enrolled members, and the ratios meet or exceed established standards. The MCO has a sufficient number of providers relative to its member population, and the provider network is adequacy distributed to meet member needs. Additionally, the data used to calculate the ratios is completed, current, and free from significant errors or inconsistencies. **Wait Time to Receive Services:** MCW FCP's wait time validation confirmed compliance with established timelines for the identified provider types.
Weaknesses/Opportunities for Improvement

MCO Level
Member to Provider Ratio: Although the overall member to provider ratio was above 90 percent for FC, the consultative clinical and therapeutic services for caregivers service type did not meet the network adequacy standards in several counties. **Wait Time to Receive Services:** Opportunities to improve timely access were identified for FC in the areas of adaptive aids, assistive technology, DME, DMS, communication aids, and consumer education. DME was also an area of opportunity for FCP. In many cases, the MCO did not provide evidence of a service start date.
Recommendations
Member to Provider Ratio: Improve the network of providers in the service type that did not meet the member to provider ratio standard in all counties for FC. **Wait Time to Receive Services:** Decrease wait times for those provider types that did not meet the wait time standards.

Validation of Network Adequacy - Progress on Prior Recommendations

MetaStar assessed the degree that the organizations effectively addressed recommendations for quality improvement made during the previous review. The following rating scale was applied.

Table 78. Degree to Which the Organizations Addressed the Recommendations

Degree	Description
High	The organizations addressed all recommendations.
Medium	The organizations addressed half of the recommendations, but not all.
Low	The organizations addressed less than half of the recommendations.
N/A	No recommendations received.

The following table identifies the recommendations made in the prior review, the actions taken to address the recommendations, and the degree to which the organizations addressed the recommendations. If no actions were taken, or were insufficient to address the recommendation, they will not be listed in the corresponding column.

Table 79. Progress on Prior Recommendations

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
– 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 FC 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 FCP 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	– FC programs took action to address the member to provider ratio in all counties for the following service types: ○ 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 – FCP programs took action to address the member to provider ratio in all counties for the following service types: ○ 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 - The PACE program took action to address the member to provider ratio in all counties for Mental Health Day Treatment providers.	Medium

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
member to provider ratio standard in all counties.		

The table below identifies the recommendations made by the EQRO in the prior review, FY 23-24, the actions taken by the MCOs to address the recommendations, and the degree to which the MCOs addressed the recommendations. If no actions were taken, or were insufficient to address the recommendation, they will not be listed in the corresponding column.

Table 80. MCO-Level Progress

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCI	Improve the network of providers in the service types that did not meet the member to provider ratio standard in all counties: Family Care: – 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. Family Care Partnership: – Mental Health Day Treatment Services (in all settings).	– Preliminary results for CCI's Family Care program in CY 2024 continue to reflect an inadequate number of providers for Mental Health Day Treatment and Community Support indicators. However, both Family Care Partnership and PACE programs have no service areas that reflect a shortage of services.	Medium
*i*Care	Improve the FC 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).	– *i*Care's FC program year two preliminary results for CY 2024 show improvement in these identified services. Transportation (specialized transportation) – other transportation has been identified as the top service not meeting network adequacy indicators. The overall result improved slightly from 93.0 to 93.3 percent.	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Prevocational Services. Improve the FCP 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. – Transportation (excluding Ambulance). – Alcohol and Other Drug Abuse (AODA) Day Treatment. – Counseling and Therapeutic Resources. – Prevocational Services. – Supported Employment - Small Group Employment Support.	– *i*Care's FCP program's year two preliminary results for CY 2024 show improvement in these identified services except for transportation services.	
LCI	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.	– LCI's year two preliminary results show improvement in some service types and regression in others. The top issues are consistent between the current and prior reports.	Low
MCW	Improve the network of providers in the service types that did not meet the member to provider ratio standard in all counties: Family Care – Transportation (excluding ambulance).	– MCW improved in all service areas identified last year.	High

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Transportation (specialized transportation) – Other Transportation. – Adult Residential Care – Residential Care Apartment Complex. Family Care Partnership: – Transportation (specialized transportation) – Other Transportation. – Ensure locations of services in the provider directory and provider extract match for both Family Care and Family Care Partnership.		

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

The review of each MCOs' and PIHPs' care management practices is an optional EQR activity identified in 42 CFR § 438.358. Review activities are conducted according to federal protocol. See Appendix 1 for more information about the CMR review methodology.

The information collected during the CMR is used to evaluate the accessibility, timeliness, quality, and appropriateness of care provided by MCOs to their members. CMR activities and findings contribute to DHS' broader strategy for assuring the quality of services delivered under the 1915(c) HCBS Waiver, which authorizes the operation of FC programs in the state.

The CMR includes an assessment of key care management practices, with compliance thresholds established in collaboration with DHS.

Member Assessments

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.

Member Centered Planning

The 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.

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;
- The IDT maintained regular contact with the member to monitor ongoing needs and ensure continuity of care; and
- The IDT ensured that the member's rights were upheld throughout the coordination and delivery of services.

LTCFS

The 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:

- Diagnoses;
- ADLs;
- IADLs;
- Additional Supports;
- HRS;
- Communication and Cognition;
- Behavioral Health; and

- Risk.

The member's LTCFS must align with MCO documentation, including the comprehensive assessment and MCP. The member's LTCFS ratings should be clearly reflected in the MCP and assessment. Additionally, when a member experiences a change in condition, the LTCFS must be updated to accurately reflect that change

Quality of Care

The MCO is responsible for assuring all health, safety, and welfare needs of its members. 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.

The key areas of care management practice were structured into a review tool, with each requirement grouped under specific indicators. The table below identifies each indicator along with a description of what the measure is intended to ensure.

Table 81. CMR Review Tool

Indicator	Indicator Label	Indicator Description
1A	Comprehensive Assessment	Ensures the MCO evaluates member needs.
1B	Timely Assessment	Ensures assessments are conducted by both IDT members at least every six months.
2A	Comprehensive MCP	Ensures MCPs address all assessed needs.
2B	Timely MCP	Ensures MCPs are reviewed and signed by the member or legal decision maker at least every six months.
2C	MCP Signed Annually	Ensures MCPs are signed by the member or legal decision maker at least once per year.
2D	Change in Condition	Ensures the IDT assesses members when changes in condition occur and updates the MCP as needed. Only applies to members that had a change in condition during the review period.
2E	Service Authorizations	Ensures the IDT appropriately handles service authorizations, responds to member requests, and issues *Notices of Adverse Benefit Determination* when applicable.
2F	Essential Providers	Ensures the MCO obtains signatures on the MCP from all essential waiver service providers once per year.

Indicator	Indicator Label	Indicator Description
		Only applies to members that had an essential provider.
3A	Timely Coordination	Ensures the IDT implements timely and effective plans to coordinate member needs and supports.
3B	Timely Follow-Up	Ensures the IDT follows up with members to confirm that services and supports were received and are effective.
3C	Member Rights	Ensures the IDT upheld member rights by including the member and their supports in care management processes, offering and explaining the SDS option, and following applicable guidelines for restrictive measures and rights limitations.
3D	IDT Contact	Ensures the IDT has monthly collateral contact, face-to-face contact with the member at least every three months, and an annual home visit with the member.
4A	LTCFS Consistency	Ensures consistency between documentation on the member's LTCFS and the member's record, including assessments and the MCP.
4B	LTCFS Rescreen	Ensures the MCO completes a rescreen when there is a change in condition. Only applies to members that had a change in condition during the review period.
5A	Quality of Care	Ensures the MCO adequately supports all health, safety, and welfare needs of members.

To conduct the review, MetaStar selects a random sample of members from each MCO and program. Each MCO has a different review period, as reviews are conducted on a rolling basis. The samples are statistically representative, with a 90 percent confidence level and a 5 percent margin of error. The tables below show the sample sizes and review periods for each MCO and program.

Table 82. FC Samples Sizes and Review Period

MCO	Records Reviewed	Review Period
CCI	259	03/1/24 – 08/31/24
*i*Care	266	01/1/24 – 06/30/24
LCI	261	07/1/24 – 12/31/24
MCW	266	10/1/24 – 03/31/25

Table 83. FCP Samples Sizes and Review Period

MCO	Records Reviewed	Review Period
CCI	197	03/1/24 – 08/31/24
*i*Care	230	01/1/24 – 06/30/24
MCW	225	10/1/24 – 03/31/25

Table 84. PACE Samples Sizes and Review Period

MCO	Records Reviewed	Review Period
CCI	168	03/1/24 – 08/31/24

Care Management Review – Results

This report addresses the review of care management practices for the review periods specified in the table above, with reviews conducted in FY 24-25. Compliance is reported in terms of a percentage score, a star rating that correlates with the *DHS Score Card*, and a compliance rating identified in the table below. See Appendix 1 for more information about the scoring methodology.

Table 85. CMR Scoring Legend

Score	Stars	Compliance Rating
95.0% - 100.0%	★★★★★	Fully Met
90.0% - 94.9%	★★★★½	Fully Met
85.0% - 89.9%	★★★★	Substantially Met
80.0% - 84.9%	★★★½	Substantially Met
75.0% - 79.9%	★★★	Partially Met
70.0% - 74.9%	★★½	Partially Met
65.0% - 69.9%	★★	Minimally Met
60.0% - 64.9%	★½	Minimally Met
55.0%-59.9%	★	Not Met
≤ 54.9%	½	Not Met

To assess whether there has been a statistically significant change in rates year over year, MetaStar used a **Pearson's Chi-Square Test of Independence**. This test evaluated whether the distribution of responses or outcomes in one year differs from that in another, beyond what might be expected by random chance. It compared the observed frequencies in each category to the frequencies expected if there were no change over time. A significant result, typically p <

0.05, suggests that the differences in proportions across years are unlikely to be due to random variation alone.

The table below presents the percentage and compliance rating achieved by the FC program for FY 24–25. For comparison, the score from FY 23–24 is also included, along with the direction of change.

Table 86. FC CMR Results

Indicator	Indicator Label	FY 24-25 Percentage Score	Stars	Compliance Rating	FY 23-24 Percentage Score	Change
1A	Comprehensive Assessment	94.2%	★★★★½	Fully Met	75.9%	▲
1B	Timely Assessment	97.1%	★★★★★	Fully Met	96.6%	NS
2A	Comprehensive MCP	84.5%	★★★½	Substantially Met	67.1%	NC
2B	Timely MCP	84.7%	★★★½	Substantially Met	82.6%	NS
2C	MCP Signed Annually	97.2%	★★★★★	Fully Met	96.1%	NS
2D	Change in Condition	92.5%	★★★★½	Fully Met	90.1%	NS
2E	Service Authorizations	89.0%	★★★★	Substantially Met	91.9%	▼
2F	Essential Providers	88.7%	★★★★	Substantially Met	83.2%	▲
3A	Timely Coordination	97.6%	★★★★★	Fully Met	95.1%	▲
3B	Timely Follow-Up	62.2%	★½	Minimally Met	64.0%	NS
3C	Member Rights	96.8%	★★★★★	Fully Met	96.3%	NS
3D	IDT Contact	92.1%	★★★★½	Fully Met	89.4%	▲
4A	LTCFS Consistency	59.8%	★	Not Met	56.6%	NS
4B	LTCFS Rescreen	46.0%	½	Not Met	35.0%	NS
5A	Quality of Care	99.5%	★★★★★	Fully Met	99.6%	NS

Significant Increase = ▲, Significant Decrease = ▼, No Significant Change = NS, Not Comparable = NC

The following table displays the percentage scores achieved by each FC MCO in FY 24–25.

Table 87. FC CMR Results by MCO

Indicator	Indicator Label	CCI	*i*Care	LCI	MCW
1A	Comprehensive Assessment	96.1%	85.7%	100.0%	95.1%
1B	Timely Assessment	99.2%	96.2%	98.9%	94.4%
2A	Comprehensive MCP	83.8%	72.6%	91.6%	90.2%
2B	Timely MCP	87.3%	81.6%	85.4%	84.6%
2C	MCP Signed Annually	96.9%	97.7%	96.9%	97.4%
2D	Change in Condition	89.6%	90.4%	89.2%	97.9%
2E	Service Authorizations	91.5%	86.5%	92.7%	85.3%
2F	Essential Providers	91.1%	75.9%	94.7%	92.2%
3A	Timely Coordination	96.9%	98.1%	99.2%	96.2%
3B	Timely Follow-Up	70.3%	57.5%	66.7%	54.5%
3C	Member Rights	96.5%	97.0%	96.6%	97.0%
3D	IDT Contact	95.8%	86.5%	98.1%	88.3%
4A	LTCFS Consistency	67.8%	45.2%	60.1%	66.5%
4B	LTCFS Rescreen	52.6%	50.0%	19.0%	60.0%
5A	Quality of Care	99.6%	100.0%	98.9%	99.6%

The table below presents the percentage and compliance rating achieved by the FCP program for FY 24–25. For comparison, the score from FY 23–24 is also included, along with the direction of change.

Table 88. FCP CMR Results

Indicator	Indicator Label	FY 24-25 Percentage Score	Stars	Compliance Rating	FY 23-24 Percentage Score	Change
1A	Comprehensive Assessment	94.2%	★★★★½	Fully Met	85.7%	▲
1B	Timely Assessment	96.9%	★★★★★	Fully Met	96.7%	NS
2A	Comprehensive MCP	80.4%	★★★½	Substantially Met	84.2%	NC
2B	Timely MCP	81.6%	★★★½	Substantially Met	82.1%	NS
2C	MCP Signed Annually	95.1%	★★★★★	Fully Met	94.7%	NS

Indicator	Indicator Label	FY 24-25 Percentage Score	Stars	Compliance Rating	FY 23-24 Percentage Score	Change
2D	Change in Condition	91.5%	★★★★½	Fully Met	91.7%	NS
2E	Service Authorizations	89.6%	★★★★	Substantially Met	91.6%	NS
2F	Essential Providers	79.6%	★★★	Partially Met	87.0%	▼
3A	Timely Coordination	97.1%	★★★★★	Fully Met	92.1%	▲
3B	Timely Follow-Up	56.6%	★	Not Met	64.2%	▼
3C	Member Rights	94.2%	★★★★½	Fully Met	93.8%	NS
3D	IDT Contact	85.9%	★★★★	Substantially Met	89.3%	NS
4A	LTCFS Consistency	44.2%	½	Not Met	53.2%	▼
4B	LTCFS Rescreen	46.0%	½	Not Met	27.8%	▲
5A	Quality of Care	99.7%	★★★★★	Fully Met	99.5%	NS

Significant Increase = ▲, Significant Decrease = ▼, No Significant Change = NS, Not Comparable = NC

The table below displays the percentage scores achieved by each FCP MCO in FY 24–25.

Table 89. FCP CMR Results by MCO

Indicator	Indicator Label	CCI	*i*Care	MCW
1A	Comprehensive Assessment	94.9%	90.0%	97.8%
1B	Timely Assessment	97.5%	97.0%	96.4%
2A	Comprehensive MCP	84.8%	67.0%	90.2%
2B	Timely MCP	86.8%	79.6%	79.1%
2C	MCP Signed Annually	97.0%	92.6%	96.0%
2D	Change in Condition	96.4%	83.3%	95.4%
2E	Service Authorizations	90.9%	86.5%	91.6%
2F	Essential Providers	87.9%	65.3%	86.9%
3A	Timely Coordination	96.4%	96.5%	98.2%
3B	Timely Follow-Up	66.0%	50.9%	54.2%

Indicator	Indicator Label	CCI	*i*Care	MCW
3C	Member Rights	96.4%	90.4%	96.0%
3D	IDT Contact	94.4%	82.2%	82.2%
4A	LTCFS Consistency	64.3%	27.2%	45.3%
4B	LTCFS Rescreen	47.4%	52.0%	36.8%
5A	Quality of Care	100.0%	99.1%	100.0%

The table below presents the percentage and compliance rating achieved by the PACE program for FY 24–25. For comparison, the score from FY 23–24 is also included, along with the direction of change. CCI is the only MCO operating the PACE program; therefore, there is no table showing MCO comparison for the program.

Table 90. PACE CMR Results

Indicator	Indicator Label	FY 24-25 Percentage Score	Stars	Compliance Rating	FY 23-24 Percentage Score	Change
1A	Comprehensive Assessment	93.5%	★★★★½	Fully Met	90.9%	NS
1B	Timely Assessment	95.8%	★★★★★	Fully Met	94.9%	NS
2A	Comprehensive MCP	94.6%	★★★★½	Fully Met	96.0%	NC
2B	Timely MCP	93.5%	★★★★½	Fully Met	89.7%	NS
2C	MCP Signed Annually	98.8%	★★★★★	Fully Met	99.4%	NS
2D	Change in Condition	96.9%	★★★★★	Fully Met	96.2%	NS
2E	Service Authorizations	94.6%	★★★★½	Fully Met	96.6%	NS
2F	Essential Providers	88.8%	★★★★	Substantially Met	92.8%	NS
3A	Timely Coordination	98.8%	★★★★★	Fully Met	97.7%	NS
3B	Timely Follow-Up	85.7%	★★★★	Substantially Met	81.7%	NS
3C	Member Rights	98.2%	★★★★★	Fully Met	99.4%	NS
3D	IDT Contact	98.8%	★★★★★	Fully Met	96.6%	NS

Indicator	Indicator Label	FY 24-25 Percentage Score	Stars	Compliance Rating	FY 23-24 Percentage Score	Change
4A	LTCFS Consistency	75.7%	★★★	Partially Met	59.3%	▲
4B	LTCFS Rescreen	61.5%	★½	Minimally Met	63.0%	NS
5A	Quality of Care	100.0%	★★★★★	Fully Met	99.4%	NS

Significant Increase = ▲, Significant Decrease = ▼, No Significant Change = NS, Not Comparable = NC

Care Management Review - State Level Findings

The following table identifies strengths, weaknesses/opportunities for improvement and recommendations for each standard reviewed. Strengths are given for standards that scored at or above 90 percent. Weaknesses, or opportunities for improvement, are included for any standard that is below 90 percent, and any scoring element that was not met. Additional opportunities for improvement may be included for elements that are minimally compliant. Recommendations are provided for all identified weaknesses and opportunities for improvement.

Table 91. CMR Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Care Management Strengths, Weaknesses/Opportunities for Improvement, and Recommendations
Member Assessments
Strengths: All programs demonstrated strong and effective practices in conducting comprehensive member assessments through their IDTs. These teams consistently explored and documented a wide range of member-specific information, including personal experience outcomes, long-term care goals, individual strengths and preferences, natural and community supports, health and safety risks, and ongoing clinical or functional conditions requiring long-term care, treatment, or regular monitoring. Notably, both FC and FCP programs showed significant improvement from the prior review period, reflecting enhanced consistency and depth in assessment practices. All initial assessments and reassessments are completed within the timelines and requirements outlined in the DHS-MCO contract, underscoring the programs' commitment to regulatory compliance and high-quality, person-centered care planning. These improvements highlight a strong culture of continuous quality enhancement across the programs.
Weaknesses/Opportunities for Improvement: None identified
Recommendations: None identified.
Member Centered Planning
Strengths: The PACE program demonstrated strong compliance with DHS-MCO contract requirements through timely development and updates of MCPs and service authorizations. Authorized services align

Care Management Strengths, Weaknesses/Opportunities for Improvement, and Recommendations
with comprehensive assessments and effectively support members' health, safety, and long-term care outcomes. Documentation shows timely decision-making on service requests and identified needs, and IDT staff consistently assess and respond to member-specific risks, reinforcing a person-centered and proactive approach to care. Additionally, the FC and FCP programs showed strengths in maintaining MCPs through timely annual reviews and updates following changes in condition, reinforcing their commitment to person-centered care and responsiveness.
Weaknesses/Opportunities for Improvement: • In the FC and FCP programs, MCPs were not consistently comprehensive. In multiple instances, members had assessed needs, particularly related to ADLs, without corresponding supports documented in the MCP. Additionally, supports for mental/behavioral health and wellness needs were frequently missing **(2A)**. • MCPs were not consistently reviewed or signed every six months as required in the FC and FCP programs **(2B)**. This lapse in documentation may impact care coordination and compliance with DHS-MCO contract standards, and could result in outdated plans that do not reflect members' current needs or preferences. • In the FC and FCP programs, service authorizations were not consistently handled in accordance with DHS-MCO contract requirements **(2E)**. Specifically, *Notices of Adverse Benefit Determinations* were not issued when members requested new services and no decision was made, or when previously authorized services were reduced, suspended, or terminated. These omissions may result in members not receiving required notifications or having the opportunity to appeal, impacting transparency and member rights. • Across the FC, FCP, and PACE programs, there were instances of non-compliance with essential provider requirements, particularly related to SHC providers **(2F)**.
Recommendations: • Ensure MCPs consistently reflect all assessed needs by strengthening IDT practices for linking ADL, mental/behavioral health, and wellness needs to appropriate supports and services during care planning and updates **(2A)**. • Ensure MCPs are reviewed and signed at least every six months by implementing tracking systems and regular IDT audits to support timely updates and compliance with DHS-MCO contract requirements **(2B)**. • Strengthen service authorization practices by ensuring *Notices of Adverse Benefit Determinations* are issued when decisions are not made timely on member requests for new services and when authorized services are reduced, suspended, or terminated, to maintain compliance and protect member rights **(2E)**. • Ensure compliance with essential provider requirements by regularly reviewing and updating documentation for SHC providers, and implementing monitoring processes to verify contract adherence **(2F)**.
Care Coordination

Care Management Strengths, Weaknesses/Opportunities for Improvement, and Recommendations
Strengths: All programs demonstrated strong practices in care coordination through the IDT. Records showed that IDT staff coordinated services and supports in a timely manner and upheld member rights throughout service delivery. Additionally, FC and PACE maintained regular contact with members to monitor ongoing needs. These practices reflect a consistent commitment to person-centered care and continuity of services.
Weaknesses/Opportunities for Improvement: • Across the FC, FCP, and PACE programs, IDT staff did not consistently follow up with members in a timely manner to confirm that services and supports were received and effective. This issue was frequently related to lack of follow-up on medical appointments, service provider engagement, and DME needs, such as wheelchair repairs **(3B)**. These gaps may hinder the ability to ensure service effectiveness, address unmet needs, and maintain member safety and satisfaction. • The FCP program did not consistently meet minimum contact requirements with members, particularly missing required monthly collateral contacts **(3D)**. These lapses may affect timely identification of changes in member needs, reduce opportunities for proactive care coordination, and result in non-compliance with DHS-MCO contract standards.
Recommendations: • Improve follow-up practices by ensuring IDT staff consistently confirm that members received services, such as medical appointments, provider visits, and DME repairs, and assess their effectiveness, using timely documentation and tracking tools **(3B)**. • Ensure FCP staff meet minimum contact requirements by implementing tracking tools and regular oversight to verify timely completion of monthly collateral contacts and maintain compliance with contract standards **(3D)**.
LTCFS
Strengths: None identified.
Weaknesses/Opportunities for Improvement: • None of the programs demonstrated compliance with requirements for aligning the LTCFS with MCO documentation **(4A)**. Member assessments and MCPs often did not reflect the LTCFS ratings particularly in areas related to mobility, toileting, and HRS needs. • LTCFS updates were frequently missing following changes in member condition, resulting in inaccurate functional eligibility documentation and potential gaps in care planning **(4B)**.
Recommendations: • Ensure LTCFS ratings, especially for mobility, toileting, and HRS needs, are accurately reflected in member assessments and MCPs by strengthening documentation practices and updating the LTCFS promptly following changes in condition **(4A)**. • Ensure timely updates to the LTCFS following any change in member condition by implementing clear protocols and regular monitoring to maintain accurate functional eligibility and support effective care planning **(4B)**.
Quality of Care
Strengths: All programs demonstrated strong practices in addressing member health, safety, and welfare. Records showed that IDT staff actively identified and responded to member risks, upheld member rights, and ensured members were not using personal resources for covered services without

Care Management Strengths, Weaknesses/Opportunities for Improvement, and Recommendations
appropriate counseling. These practices reflect a strong commitment to member protection and contract compliance.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.

Care Management Review – Managed Care Organization Level Findings

Community Care, Inc.

The following results provide an overview of the review conducted for CCI.

Table 92. CCI CMR Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• Comprehensive assessment practices were strengths for the organization in all programs. • The organization had strong practices in place for member centered planning in all programs. • PACE demonstrated strengths related to care coordination. • All programs demonstrated strengths in assuring health and safety needs of members were satisfied.
Weaknesses/Opportunities for Improvement
• FC and FCP programs need to improve the comprehensiveness of MCPs, despite ongoing monitoring and feedback efforts **(2A)**. • MCPs in the FC and FCP programs were not consistently developed or updated within required timeframes **(2B)**. • FC program staff did not consistently assess members or update MCPs following changes in condition **(2D)**. • All programs showed gaps in issuing required notices when services were denied, reduced, suspended, or terminated **(2E)**. • FCP and PACE programs did not consistently distribute MCPs to essential providers, impacting coordination of care **(2F)**. • All programs lacked consistent documentation of follow-up activities, despite existing monitoring and feedback practices **(3B)**. • All programs showed inconsistencies between the LTCFS and MCO documentation, particularly in key care areas **(4A)**. • LTCFS rescreening was not consistently completed following changes in member condition across all programs **(4B)**.
Recommendations
• Focus efforts on improving the comprehensiveness of MCPs, and continue current monitoring and feedback practices in the FC and FCP programs **(2A)**.

MCO Level
• Improve timeliness of MCPs in the FC and FCP programs **(2B)**. • Ensure FC members are assessed and MCPs updated when needed following a change in condition **(2D)**. • Focus efforts to ensure notices are issued when indicated in all programs **(2E)**. • Improve distribution of MCPs to essential providers in the FCP and PACE programs **(2F)**. • Focus efforts on improving documentation of follow-up activities and continue current monitoring and feedback practices in all programs **(3B)**. • Focus effort to improve consistency between the LTCFS and MCO documentation in all programs **(4A)**. • Ensure rescreening occurs following a change a condition in all programs **(4B)**.

Independent Care Health Plan

The following results provide an overview of the review conducted for *i*Care.

Table 93. *i*Care CMR Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• Comprehensive assessment practices were strengths for the organization. • The organization demonstrated strengths in assuring health and safety needs of members were satisfied.
Weaknesses/Opportunities for Improvement
• Member assessments in the FC program were not consistently comprehensive, limiting the effectiveness of care planning **(1A)**. • MCPs lacked sufficient detail in both programs, indicating a need for improved comprehensiveness **(2A)**. • FC and FCP programs did not consistently ensure members or legal decision makers reviewed and signed MCPs every six months **(2B)**. • Reassessments and MCP updates were not consistently completed following changes in condition for FCP members **(2D)**. • Decisions on member service requests were not always made timely, and required notices were not consistently issued in both programs **(2E)**. • Essential provider signatures were missing from MCPs in both programs **(2F)**. • Documentation of follow-up activities was inconsistent in both programs, despite existing monitoring and feedback practices **(3B)**. • Required member contacts were not consistently completed in the FCP program **(3D)**. • Documentation in member records did not consistently align with the LTCFS **(4A)**. • LTCFS rescreens were not completed when indicated in both programs **(4B)**.

MCO Level
Recommendations
• Improve comprehensiveness of member assessments in the FC program **(1A)**. • Focus efforts on improving the comprehensiveness of MCPs, and continue current monitoring and feedback practices in both programs **(2A)**. • Ensure FC and FCP members or legal decision makers review and sign MCPs every six months **(2B)**. • Complete reassessments and updates to MCPs when changes occur for FCP members **(2D)**. • Focus efforts to ensure decisions are made timely on member requests for services and notices are issued timely when indicated in both programs **(2E)**. • Ensure signatures from essential providers are obtained as required in both programs **(2F)**. • Focus efforts on improving documentation of follow-up activities and continue current monitoring and feedback practices in both programs **(3B)**. • Complete member contacts as required in the FCP program **(3D)**. • Improve documentation consistency between the LTCFS and the member's record at the organization **(4A)**. • Complete rescreens when indicated for both programs **(4B)**.

Lakeland Care, Inc.

The following results provide an overview of the review conducted for LCI.

Table 94. LCI CMR Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• Comprehensive assessment practices were strengths for the organization. • The organization had strong practices in place for member centered planning. • The organization demonstrated strengths related to care coordination. • The organization demonstrated strengths in assuring health and safety needs of members were satisfied.
Weaknesses/Opportunities for Improvement
• MCPs were not consistently developed or updated within required timeframes, impacting care coordination and compliance **(2B)**. • Members were not consistently reassessed or had their MCPs updated following changes in condition, leading to potential gaps in care planning **(2D)**. • Documentation of follow-up activities was inconsistent, limiting the ability to confirm service effectiveness and address member needs **(3B)**. • The LTCFS did not consistently align with MCO documentation, resulting in discrepancies in member records **(4A)**.

MCO Level
• LTCFS rescreening was not consistently completed following changes in member condition, affecting the accuracy of functional eligibility and care planning **(4B)**.
Recommendations
• Improve timeliness of MCPs **(2B)**. • Ensure members are assessed and MCPs are updated, when needed, following a change in condition **(2D)**. • Focus efforts on improving documentation of follow-up activities and continue current monitoring and feedback practices **(3B)**. • Focus efforts to improve consistency between the LTCFS and MCO documentation **(4A)**. • Ensure rescreening occurs following a change a condition **(4B)**.

My Choice Wisconsin

The following results provide an overview of the review conducted for MCW.

Table 95. MCW CMR Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• Comprehensive assessment practices were strengths for the organization in both programs. • The organization had strong practices in place for member centered planning in the FC program. • Both programs demonstrated strengths in assuring health and safety needs of members were satisfied.
Weaknesses/Opportunities for Improvement
• MCPs are not consistently developed in a timely manner across both programs, potentially impacting the coordination and delivery of services **(2B)**. • Required notices are not always issued when indicated, leading to gaps in communication and potential non-compliance across all programs **(2E)**. • MCPs are not reliably distributed to essential providers within the FC program **(2F)**. • Follow-up activities to assess the effectiveness of services are not consistently timely, which may affect service outcomes despite ongoing monitoring and feedback practices **(3B)**. • Member contacts are not consistently completed as required in both programs, which may result in missed opportunities to address member needs and ensure service appropriateness **(3D)**. • Discrepancies exist between the LTCFS and MCO documentation **(4A)**. • LTCFS rescreening is not consistently conducted following a change in a member's condition **(4B)**.
Recommendations
• Improve timeliness of MCPs in both programs **(2B)**. • Focus efforts to ensure notices are issued when indicated in all programs **(2E)**.

MCO Level
• Improve distribution of MCPs to essential providers in the FC program **(2F)**. • Focus efforts on improving timely follow-up for effectiveness of services and continue current monitoring and feedback practices in both programs **(3B)**. • Complete member contacts as required in both programs **(3D)**. • Focus efforts to improve consistency between the LTCFS and MCO documentation in both programs **(4A)**. • Ensure rescreening occurs following a change a condition in both programs **(4B)**.

Care Management Review - Progress on Prior Recommendations

MetaStar assessed the degree that the organizations effectively addressed recommendations for quality improvement made during the previous review. The following rating scale was applied.

Table 96. Degree to Which the Organizations Addressed the Recommendations

Degree	Description
High	The organizations addressed all recommendations.
Medium	The organization addressed half of the recommendations, but not all.
Low	The organization addressed less than half of the recommendations.
N/A	No recommendations received.

The following table identifies the state-level recommendations made in the prior review, the actions taken to address the recommendations, and the degree to which the organizations addressed the recommendations. If no actions were taken, or were insufficient to address the recommendation, they will not be listed in the corresponding column.

Table 97. State-Level Progress on Prior Recommendations

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
– Focus efforts to improve the comprehensiveness of assessments in the FC and FCP programs **(1A)**.	– The MCOs took action to include all criteria in the comprehensive assessments for FC and FCP members **(1A)**.	Medium

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
– Improve comprehensiveness of MCPs in the FC and FCP programs **(2A)**. – Improve timeliness of MCPs in all programs **(2B)**. – Ensure essential provider requirements are satisfied in the FC and FCP programs **(2F)**. – Conduct a root cause analysis to identify the cause and barriers to improving the timeliness of follow-up to member services in all programs **(3B)**. – Ensure minimum contact with members is being conducted in the FC and FCP programs **(3D)**. – Focus efforts on improving the consistency between the LTCFS and organization documentation in all programs **(4A)**. – Improve practices to conduct rescreens when warranted in all programs **(4B)**.	– The FC program took action to improve compliance with essential provider requirements **(2F)**. – Minimum contacts improved in the FC program **(3D)**. – PACE demonstrated significant improvement in ensuring consistency between the LTCFS and MCO documentation **(4A)**. – FCP demonstrated significant improvement in rescreening members for changes in condition **(4B)**.	

The following table identifies the recommendations made by the EQRO in the prior review, FY 23-24, the actions taken by the MCOs to address the recommendations, and the degree to which the MCOs addressed the recommendations. If no actions were taken, or were insufficient to address the recommendation, they will not be listed in the corresponding column.

Table 98. MCO-Level Progress

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCI	– Ensure the FC and FCP programs evaluate the new assessment criteria as part of comprehensive assessments **(1A)**. – Focus efforts to improve the comprehensiveness of MCPs in the	– The MCO took action to include all criteria in the comprehensive assessments for all programs **(1A)**. – Distribution of MCPs to self-directed support caregivers improved in the FC program **(2F)**.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	FC and FCP programs by ensuring each assessed member need has a support, such as a caregiver, included on the plan **(2A)**. – Improve the timeliness of MCP reviews in all programs by obtaining signatures from the member or legal decision maker every six months **(2B)**. – Ensure MCPs are updated following a change in member condition in the FC program **(2D)**. – Focus efforts to ensure notices are issued timely and when indicated in all programs **(2E)**. – Improve the distribution of MCPs to self-directed support caregivers in the FC program **(2F)**. – Prioritize efforts to improve evidence of follow-up in all programs, specifically for member medical appointments, in all programs **(3B)**. – Improve consistency between the LTCFS and the organization's documentation, especially related to durable medical equipment for activities of daily living, in all programs **(4A)**. – Ensure members are re-screened following the receipt of a new service or support, such as skilled therapy or wound care, in all programs **(4B)**.		
*i*Care	– Improve comprehensiveness of assessments through fully implementing the new assessment criteria in the FC program **(1A)**. – Focus efforts to ensure each assessed need has a support	– The FC program took actions to improve the comprehensiveness of member assessments **(1A)**. – Practices to rescreen for changes in condition improved in the FC program **(4B)**.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	identified on the MCP in both programs **(2A)**. – Review MCPs timely with the member or legal decision maker in the FC program **(2B)**. – Reassess FC members for potential changes in condition following significant events, such as hospitalization or emergency room visits **(2D)**. – Ensure *Notices of Adverse Benefit Determination* are issued when indicated for both programs **(2E)**. – Obtain signatures for all essential providers in both programs **(2F)**. – Improve follow-up to ensure services and supports are received, effective, and satisfactory in both programs **(3B)**. – Ensure contact with members is completed as required in both programs **(3D)**. – Conduct a root cause analysis to identify a successful approach to improving consistency between the LTCFS and the organization's documentation for both programs **(4A)**. – Rescreen FC and FCP members when changes in condition occur **(4B)**.		
LCI	– Focus efforts to ensure each assessed need has a support identified on the MCP **(2A)**. – Update MCPs following changes in members' condition **(2D)**. – Ensure *Notices of Adverse Benefit Determination* are issued when indicated **(2E)**.	– No progress was identified.	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Focus efforts on conducting follow-up activities to ensure services and supports are received, effective, and satisfactory **(3B)**. – Conduct a root cause analysis to identify a successful approach to improving consistency between the LTCFS and the organization's documentation **(4A)**. – Rescreen members when changes in condition occur **(4B)**.		
MCW	– Focus efforts to improve the comprehensiveness of assessments in the FCP program **(1A)**. – Ensure MCPs in the FC program include services or supports for all assessed needs **(2A)**. – Continue efforts in both programs to improve the timeliness of MCP reviews **(2B)**. – Improve practices for obtaining signatures from essential service providers in both programs **(2F)**. – 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 **(3B)**. – Ensure contacts with members are completed as required in both programs **(3D)**. – Conduct a root cause analysis to determine barriers to achieving consistency between the LTCFS and the organization's documentation **(4A)**.	– The organization took action to include all criteria in the comprehensive assessments for both programs **(1A)**. – The organization focused efforts to obtain signatures from essential service providers in the FC program **(2F)**.	Low

Appendix A: Information Systems Capabilities Assessment

The assessment of each MCOs' and PIHPs' information systems is a mandatory EQR activity identified in 42 CFR § 438.358. Review activities are conducted according to federal protocol. See Appendix 1 for more information about the ISCA review methodology. Each MCO's information system must be able to provide the state with all data elements the state deems necessary for the mechanized claims processing and information retrieval systems it uses for the management, monitoring, and administration of its Medicaid program. The MCOs must also:

- Collect data on enrollee and provider characteristics as specified by the state provider and eligibility files, and on all services received by an enrollee regardless of payment methodology, including services sub-capitated by a MCO to a provider, through an encounter data system or other method that meets state requirements.
- Ensure that data received from providers are accurate and complete by:
    - Verifying the accuracy and timeliness of reported data;
    - Screening the data for completeness, logic, and consistency; and
    - Collecting data from providers in standardized formats to the extent feasible and appropriate.
- Make all collected data available to DHS and to CMS upon request.

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.

Information Systems Capabilities Assessment – Results

This report addresses the information systems requirements for the MCOs and programs evaluated. Findings from each MCO's ISCA, conducted within the past three years, were reviewed and incorporated into several mandatory EQR activities. The ISCA results provided

insight into each MCO's capacity to collect, manage, and report data, supporting the evaluation of compliance and performance across multiple areas.

ISCA compliance is reported in terms of a percentage score and a compliance rating identified in the table below.

Table 99. ISCA Scoring Legend

Score	Compliance Rating
90.0% - 100.0%	Fully Met
80.0% - 89.9%	Substantially Met
70.0% - 79.9%	Partially Met
60.0% - 69.9%	Minimally Met
≤59.9%	Not Met

The table below displays the aggregate results for the ISCAs conducted in FY 24-25, using the review period of July 1, 2023 – June 30, 2024. Each MCO receives an ISCA review once every three years; an ISCA was conducted for LCI during FY 24-25.

Table 100. ISCA Results

Focus Area	Scoring Elements	Percentage	Compliance Rating
Section 1: Background Information*	N/A	N/A	N/A
Section 2: Information Systems	24/24	100.0%	Fully Met
Section 3: Staffing	2/2	100.0%	Fully Met
Section 4: Security	27/27	100.0%	Fully Met
Section 5: Data Acquisition	81/81	100.0%	Fully Met
Overall	**134/134**	**100.0%**	**Fully Met**

*Section 1: Background Information is not scored, and is noted as not applicable.

Information Systems Capabilities Assessment - State Level Findings

The following table identifies strengths, weaknesses/opportunities for improvement, and recommendations for each standard reviewed. Strengths are given for standards that scored at or above 90 percent. Weaknesses, or opportunities for improvement, are included for any standard that is below 90 percent, and any scoring element that was not met. Additional

opportunities for improvement may be included for elements that are minimally compliant. Recommendations are provided for all identified weaknesses and opportunities for improvement.

Table 101. ISCA Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Section 2: Information Systems – Data Processing & Personnel
Strengths
• The organization has a strong system, that is maintained and updated by a stable and experienced information system department.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.
Section 3: Staffing
Strengths
• The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.
Section 4: Security
Strengths
• The organization's security systems meet or exceed most industry standards, ensuring consistent system and data availability.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.
Section 5: Data Acquisition Capabilities
Strengths
• The organization's processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter and performance measurement data is provided to the state.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Information Systems Capabilities Assessment – Managed Care Organization Level Findings

Community Care, Inc.

The following results provide an overview of the ISCA conducted for CCI in 2023.

Table 102. CCI ISCA Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• The organization has a strong system, that is maintained and updated by a stable and experienced information system department. • The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes. • The organization's security systems meet or exceed most industry standards, ensuring consistent system and data availability. • The organization's processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter and performance measurement data is provided to the state.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Independent Care Health Plan

The following results provide an overview of the ISCA conducted for *i*Care's FC program in 2023 and *i*Care's FCP program in 2022.

Table 103. *i*Care - FC ISCA Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• The organization has a strong system, that is maintained and updated by a stable and experienced information system department. • The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes. • The organization's security systems meet or exceed most industry standards, ensuring consistent system and data availability. • The organization's processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter and performance measurement data is provided to the state.

MCO Level
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Table 104. *i*Care - FCP ISCA Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• The organization has a strong system, that is maintained and updated by a stable and experienced information system department. • The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes. • The organization's security systems meet or exceed most industry standards, ensuring consistent system and data availability. • The organization's processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter and performance measurement data is provided to the state.
Weaknesses/Opportunities for Improvement
• Scoring element **5C.1** is about the MCO identifying any concerns about the quality or completeness of third-party data. *i*Care identified concerns with claims data from one of its third-party vendors in 2022. The encounter submission file error was discovered in October 2022 as a result of an audit completed by the MCO. *i*Care received the invoices with the vision vendor's detailed billing information, but any zero paid claim was not included in the encounter file. The audit determined the discrepancy dated back to the 2019 date of inception of the contract with the vendor. The vendor is working with the MCO, and *i*Care noted that the DHS encounter file submission will reflect the additional zero paid claims once the issue has been rectified. ***This scoring element was not met***.
Recommendations
• Continue to monitor claims from the third-party vision vendor to ensure completeness of data in the encounter submission files **(5C.1)**.

Lakeland Care, Inc.

The following results provide an overview of the ISCA conducted for LCI in 2024.

Table 105. LCI ISCA Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• The organization has a strong system, that is maintained and updated by a stable and experienced information system department.

MCO Level
• 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 is provided to the state.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified

My Choice Wisconsin

The following results provide an overview of the ISCA conducted for MCW in 2022.

Table 106. MCW ISCA Strengths, Weaknesses/Opportunities for Improvement and Recommendations

MCO Level
Strengths
• The organization has a strong system, that is maintained and updated by a stable and experienced information system department. • The organization provided evidence of a robust, ongoing training program to ensure all Medicaid data is processed accurately and within the expected timeframes. • The organization's security systems meet or exceed most industry standards, ensuring consistent system and data availability. • The organization's processes and system for collecting and maintaining administrative data and enrollment information ensure accurate encounter and performance measurement data is provided to the state.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Information Systems Capabilities Assessment - Progress on Prior Recommendations

MetaStar assessed the degree that the organizations effectively addressed recommendations for quality improvement made during the previous review. The following rating scale was applied.

Table 107. Degree to Which the Organizations Addressed the Recommendations

Degree	Description
High	The organization addressed all recommendations.
Medium	The organization addressed half of the recommendations, but not all.
Low	The organization addressed less than half of the recommendations.
N/A	No recommendations received.

The table below identifies the state-level recommendations made in the prior review, the actions taken to address the recommendations, and the degree to which the organization addressed the recommendations. If no actions were taken, or were insufficient to address the recommendation, they will not be listed in the corresponding column.

Table 108. State-Level Progress

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
– None identified.	– N/A	N/A

The table below identifies the recommendations made in the prior reviews: FY 23-24, FY 22-23, and FY 21-22; the actions taken by the MCOs to address the recommendations; and the degree to which the MCO addressed the recommendations. If no actions were taken, or were insufficient to address the recommendation, they will not be listed in the corresponding column.

Table 109. MCO-Level Progress

MCO	Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCI	– None identified.	– N/A	N/A
*i*Care - FC	– None identified.	– N/A	N/A
*i*Care - FCP	– Work with the claims processing system to obtain segment breakdowns of paper versus electronic claims, by service and by provider type, to allow the MCO to focus its efforts on service areas	– The organization improved its ability to obtain segment breakdowns of paper versus electronic claims. The MCO was able to describe the types of providers who are submitting paper claims along with the	High

MCO	Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	and providers with higher volume, cost, and need **(5A.1)**.	rationale for submitting paper claims. The organization continues to encourage these providers to transition to electronic submission of claims **(5A.1)**.	
LCI	– Continue with the implementation of the *Federal Information Processing Standards Publication*, which has built in benchmarks/milestones. The organization should review and align its progress with these Federal and State benchmarks **(4.12)**.	– The organization utilizes Microsoft BitLocker encryption for safeguarding personally identifiable information, which is centrally managed across all devices. The BitLocker encryption methods are compliant with the *Federal Information Processing Standards Publication 140-2* validation requirements **(4.12)**.	High
MCW	– No prior recommendations as the evaluation conducted in FY 22-23 was the first evaluation conducted for the MCO that was newly formed in 2020.	– N/A	N/A

Appendix 1 – Review Methodology

External Quality Review Protocol 1: Validation of Performance Improvement Projects

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 CMS' *External Quality Review Protocol 1: Validating Performance Improvement Projects, A Mandatory EQR-Related Activity.*

Activity 1: Assess the PIP Methodology

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

Standard 1: Review the Selected PIP Topic

1.1 The PIP topic was selected through a comprehensive analysis of MCO enrollee needs, care, and services.

1.2 The PIP topic considered performance on the CMS Child and Adult Core Set measures (if applicable).

1.3 The selection of the PIP topic considered input from enrollees or providers who are users of, or concerned with, specific service areas.

1.4 The PIP topic addressed care of special populations or high priority services.

1.5 The PIP topic aligned with priority areas identified by DHS and/or CMS.

Standard 2: Review the PIP Aim Statement

2.1 The PIP aim statement clearly specified the improvement strategy.

2.2 The PIP aim statement clearly specified the population for the PIP.

2.3 The PIP aim statement clearly specified the time period for the PIP.

2.4 The PIP aim statement was concise.

2.5 The PIP aim statement was answerable

2.6 The PIP aim statement was measurable

Standard 3: Review the Identified PIP Population

3.1 The project population was clearly defined in terms of the identified PIP question.
3.2 If the entire MCO population was included in the PIP, the data collection approach captured all enrollees to whom the PIP question applied.

Standard 4: Review the Sampling Method

4.1 The sampling frame contained a complete, recent, and accurate list of the target PIP population. (The sampling frame is the list from which the sample is drawn.)
4.2 The sampling method considered and specified the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error.
4.3 The sample contained a sufficient number of enrollees taking into account non-response.
4.4 The method assessed the representativeness of the sample according to subgroups, such as those defined by age, geographic location, or health status.
4.5 Valid sampling techniques were used to protect against bias.

Standard 5: Review the Selected PIP Variables and Performance Measures

5.1 The variables were adequate to answer the PIP question.

5.2 The performance measure assessed an important aspect of care that will make a difference to enrollees' health or functional status.
5.3 The performance measures were appropriate based on the availability of data and resources to collect the data.
5.4 The measures were based on current clinical knowledge or health services research.
5.5 The performance measures monitored, tracked, and compared performance over time; and informed the selection and evaluation of quality improvement activities.
5.6 The MCO considered existing measures such as CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics measures, HEDIS®, or AHRQ measures.

5.7 The MCO developed new measures based on current clinical practice guidelines or health services research if there were gaps in existing measures.

5.8 The measures captured changes in enrollee satisfaction or experience of care.

5.9 The measures included a strategy to ensure inter-rater reliability (if applicable).

5.10 The process measure is meaningfully associated with outcomes (if applicable).

Standard 6: Review the Data Collection Procedures

6.1 The PIP design specified a systematic method for collecting valid and reliable data that represents the population in the PIP.

6.2 The PIP design specified the frequency of data collection.

6.3 The PIP design clearly specified the data sources.

6.4 The PIP design clearly defined the data elements to be collected.

6.5 The data collection plan linked to the data analysis plan to ensure that appropriate data would be available for the PIP.

6.6 The data collection instruments allowed for consistent and accurate data collection over the time periods studied.

6.7 Qualitative data collection methods were well-defined and designed to collect meaningful and useful information from respondents (if applicable).

6.8 – 6.13 Administrative Data

6.14 – 6.16 Medical Record Review Data

Standard 7: Review Data Analysis and Interpretation of PIP Results

7.1 The analysis was conducted in accordance with the data analysis plan.

7.2 The analysis included baseline and repeat measurements of project outcomes.

7.3 The analysis assessed the statistical significance of any differences between the initial and repeat measurements.

7.4 The analysis accounted for factors that may influence the comparability of initial and repeat measurements.

7.5 The analysis accounted for factors that may threaten the internal or external validity of the findings.

7.6 The PIP compared the results across multiple entities, such as different patient subgroups, provider sites, or MCOs.

7.7 PIP results and findings were presented in a concise and easily understood manner.

7.8 To foster continuous quality improvement, the analysis and interpretation of the PIP data included lessons learned about less-than-optimal performance.

Standard 8: Assess the Improvement Strategies

8.1 The selected improvement strategy was evidence-based, that is, there was existing evidence (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables).

8.2 The strategy was designed to address root causes or barriers identified through data analysis and quality improvement processes.

8.3 The rapid-cycle PDSA approach was used to test the selected improvement strategy.

8.4 The strategy was culturally and linguistically appropriate.

8.5 The implementation of the strategy was designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices).

8.6 Building on the findings from the data analysis and interpretation of PIP results, the PIP assessed the extent to which the improvement strategy was successful and identify potential follow-up activities.

Standard 9: Assess the Likelihood that Significant and Sustained Improvement Occurred

9.1 The same methodology was used for baseline and repeat measurements.

9.2 There was quantitative evidence of improvement in processes or outcomes of care.

9.3 The reported improvement in performance was likely to be a result of the selected intervention.

9.4 There is statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention.

9.5 Sustained improvement was demonstrated through repeated measurements over time.

Activity 2: Perform Overall Validation and Reporting of PIP Results

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 reported 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 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.*

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. The methodology validation for each PIP includes a table listing each standard that was evaluated for the PIP methodology. The tables indicate the total number of scoring elements and percentage of scoring elements met 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 following rating scale was utilized:

- High Confidence = 90.0% - 100.0%
- Moderate Confidence = 80.0% - 89.9%
- Low Confidence = 70.0% - 79.9%
- No Confidence = <70.0%

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.

Significant Improvement Rating – The level of confidence that the PIP produced evidence of 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 organization determine baseline and repeat measurements was submitted to MetaStar for the evaluation. The following rating scale was utilized:

- High Confidence = 90.0% - 100.0%
- Moderate Confidence = 80.0% - 89.9%
- Low Confidence = 70.0% - 79.9%
- No Confidence = <70.0%

Virtual interviews are conducted with MCO staff to supplement the submitted PIP reports and ensure clear understanding of the projects, as needed. The interviews specifically address areas where the reports lacked clarify or required further explanation.

Findings were compiled into a preliminary report. The organization had the opportunity to review the findings prior to finalizing the report.

External Quality Review Protocol 2: Validation of Performance Measurements

Validating performance measures is a required EQR activity that ensures MCO-reported data is accurate and aligns with state specifications. This process confirms that MCOs can reliably collect and report data to support informed decision-making and quality improvement. MetaStar conducted these validations following CMS's *EQR Protocol 2: Validation of Performance Measures* (February 2023).

Activity 1: Conduct Pre-Virtual Visit Activities

Activity One begins with a structured approach to preparing for the validation of performance measures. The first step is to define the scope of the validation, ensuring clarity on what will be reviewed and the objectives of the process. Next, the team must assess the integrity of the MCO's information system, verifying that the data infrastructure is reliable and capable of producing accurate performance data.

Once the system's integrity is confirmed, the process moves to conducting a detailed review of the performance measures. This involves examining the methodology, data sources, and calculations used to ensure they align with established standards. Following this, the team initiates a review of medical record data collection, evaluating how records are gathered and whether they support the reported measures.

Finally, the team prepares for the MCP virtual visit, organizing materials, finalizing logistics, and ensuring all necessary documentation and tools are ready for an effective virtual visit evaluation.

Activity 2: Conduct Virtual Visit Activities

Activity Two focuses on the virtual visit evaluation of the systems and processes used by MCOs to produce performance measures. The process begins with a review of the information systems that support performance measurement, ensuring they are structured to generate accurate and reliable data. Next, the team assesses how data is integrated and controlled during the calculation of performance measures, verifying that appropriate checks and balances are in place.

Following this, the team reviews the production of performance measures, examining how data is processed and reported. A detailed review of individual measures is then completed to confirm that each one meets the required specifications.

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 assessed the validity of vaccination data reported by the MCO for each quality indicator and program during the specified measurement year (MY). The team began by reviewing data files to eliminate duplicate records and confirmed that members in the denominators met DHS technical definitions. This included verifying appropriate exclusions for contraindications and confirming age-specific vaccination data.

Numerator data was also validated to ensure vaccinations were administered within the required timeframe. MetaStar then calculated the number and percentage of unique members shared between the MCO and DHS denominators. If the MCO's denominator differed from DHS's by more than five percentage points, data resubmission was required.

Vaccination rates were calculated by quality indicator, program, and target group, and compared to both statewide rates and the MCO's prior-year performance. When discrepancies or data issues arose, MetaStar contacted the MCO for clarification.

To verify the accuracy of the MCO's reported data, MetaStar randomly selected 30 members per indicator from each program. For each selected member, MetaStar reviewed care

management records to confirm documentation of vaccinations, exclusions, and contraindications, as defined by DHS technical specifications.

Each case was assessed to determine whether the MCO's reporting was valid—meaning the appropriate vaccination was documented for the measurement year or a valid exclusion was supported. MetaStar then conducted statistical testing, using a t-test at the 95 percent confidence level, to determine whether the reported rates were unbiased. This analysis compared the MCO's reported rates to the validated sample to assess the reliability of the data.

The activity concludes with a communication of preliminary findings and any outstanding items, providing the MCO with early feedback and identifying areas that may require follow-up or clarification.

Activity 3: Conduct Post-Virtual Visit Activities

Activity Three focuses on finalizing the validation process following the site visit. It begins with determining preliminary validation findings for each performance measure, based on the data and documentation reviewed during the visit. These findings help identify whether the reported measures meet the required standards. compliance is reported in terms of a percentage score and a compliance rating identified in the table below.

Score	Compliance Rating
90.0% - 100.0%	Fully Met
80.0% - 89.9%	Substantially Met
70.0% - 79.9%	Partially Met
60.0% - 69.9%	Minimally Met
≤59.9%	Not Met

Next, the team assesses and documents the accuracy of the MCO's performance measure reports, ensuring that all calculations and data align with technical specifications and reflect valid results. The process concludes with the submission of a comprehensive validation report to the state, summarizing the findings, identifying any discrepancies, and providing recommendations for improvement if needed.

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

Compliance with Standards Review is a required EQR activity, evaluates MCO policies, procedures, and practices affecting care quality, timeliness, and access. Using CMS's *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations*, MetaStar assessed MCO compliance with 42 CFR § 438, Subpart E. The review included a document review of organizational structure, internal monitoring, staff training, and other organizational practices to identify strengths and areas for improvement.

Activity 1: Establish Compliance Thresholds

In this stage, the review team collaborates with the state to gather relevant information and define compliance benchmarks. MetaStar worked with DHS to establish expectations for MCOs, including compliance thresholds and scoring rules for each applicable federal, regulatory, or contractual requirement.

To inform the review, MetaStar obtained information from:

- Current Family Care Program contracts with DHS;
- Program operation references on the DHS website;
- The previous external quality review report; and
- DHS communications with the MCO over the past 12 months.

Together, MetaStar and DHS identified 31 standards covering federal and state requirements for FC, FCP, and PACE programs. These standards are reviewed on a two-year cycle: MCO Standards in the first year, followed by QAPI and Grievance Systems in the second. DHS may also request additional standards be reviewed in any year.

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 • Emergency and post-stabilization services 42 CFR § 438.114 • Provider Selection - 42 CFR § 438.214

Focus Area	Related Sub-Categories in Review Standards
	• 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) – **5 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

Activity 2: Perform the Preliminary Review

Early contact is established with the MCO, and a thorough document review is conducted to prepare for the virtual visit. MetaStar also conducted verification activities, and requested and reviewed additional documents, as needed, to clarify information gathered during the virtual

visit. Data from Care Management Review elements were considered when assigning compliance ratings for some focus areas and sub-categories.

Activity 3: MCO Virtual Visit

This phase involves several coordinated steps. The team determines the length and timing of the virtual visit, identifies the appropriate number and types of reviewers, and develops a detailed agenda. Preparation instructions are provided to the MCO, followed by interviews with MCO staff and a concluding exit interview to summarize initial observations.

Interviews are held in order to collect additional information necessary to assess the MCO's compliance with federal and state standards and to clarify identified gaps and questions that arise from the review of the completed desk review. Participants in the interview sessions included MCO administrators, supervisors and other staff responsible for supporting care managers, staff responsible for improvement efforts and care management staff.

Activity 4: Compile and Analyze Findings

The team collects any needed supplemental information, compiles all data, and analyzes the findings to assess the MCO's compliance. 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, and a compliance rating that aligns with Protocol 3.

Score	Stars	Compliance Rating
95.0% - 100.0%	★★★★★	Fully Met
90.0% - 94.9%	★★★★½	Fully Met
85.0% - 89.9%	★★★★	Substantially Met
80.0% - 84.5%	★★★½	Substantially Met
75.0% - 79.9%	★★★	Partially Met
70.0% - 74.9%	★★½	Partially Met
65.0% - 69.9%	★★	Minimally Met
60.0% - 64.9%	★½	Minimally Met
55.0%-59.9%	★	Not Met
≤ 54.9%	½	Not Met

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.

Activity 5: Report Results to the State

The team submits a report outline, a final determination report, and any additional reports requested by the state, completing the compliance review process.

External Quality Review Protocol 4: Validation of Network Adequacy

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. 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.*

Activity 1: Define the Scope of the Validation of Quantitative Network Adequacy Standards

The EQRO identifies the standards utilized to evaluate network adequacy utilizing the DHS-MCO Contracts and DHS Quality Strategy. DHS confirms agreement with the standards.

The EQRO establishes the approach for the network adequacy validation. This includes establishing activities to validate the data, monitoring methods, results, and reporting from existing MCO network adequacy assessment activities.

Activity 2: Identify Data Sources for Validation

The EQRO identifies data needed for the validation activity. Data related to both members and providers will be needed.

This may include:

- Data and documentation from MCOs, such as provider network data files or directories, beneficiary enrollment data files, claims and encounter data files, grievance and appeals data, member experience survey results, or provider and member handbooks.
- Data and documentation from the state, such as board certification status.
- Primary data collection to validate provider directory information or assess appointment availability and hours of operation.

Activity 3: Review Information Systems Underlying Network Adequacy Monitoring

The EQRO determines if the MCO's information systems are able to collect and report accurate data related to each network adequacy indicator. The EQRO assesses the information system in three steps:

- Review the MCO's most recently completed ISCA.
- Assess processes for collecting network adequacy validation data not addressed in the ISCA.
- Interview MCO or other personnel to clarify findings, when needed.

Activity 4: Validate Network Adequacy Assessment Data, Methods, and Results

The EQRO evaluates each MCO's ability to:

- Collect reliable and valid network adequacy monitoring data;
- Use sound methods to assess the adequacy of its managed care networks; and
- Produce accurate results to support MCO and state network adequacy monitoring efforts.

Activity 5: Communicate Preliminary Findings to Each MCO

The EQRO shares preliminary network adequacy validation findings with each MCO. The EQRO prepares a preliminary validation report for each MCO. In the report, the EQRO documents findings, provides validation ratings, identifies areas of concern, and includes suggestions for improvement. Compliance is reported in terms of a percentage score and a compliance rating identified in the table below.

Percentage Score	Compliance Rating
90.0% – 100.0%	High Confidence
50.0% – 89.9%	Moderate Confidence
10.0% – 49.9%	Low Confidence
Below 10.0%	No Confidence

Activity 6: Submit Findings to the State

The EQRO compiles the results for each MCO into the annual EQR Technical Report. In the report, the EQRO will provide its assessment of each MCO's ability to:

- Collect reliable and valid network adequacy monitoring data;
- Use sound methods to assess the adequacy of its managed care networks; and
- Produce accurate results to support MCO and state network adequacy monitoring efforts.

External Quality Review Protocol 9: Conducting Focused Studies of Health Care Quality

Protocol 9 outlines a structured, five-part process for evaluating MCO compliance with Medicaid and CHIP regulations.

Activity 1: Select the Study Topic(s)

The first step in the review process is identifying the study topic(s). Topics are selected based on alignment with the goals of the quality strategy and areas where improvement or enhanced performance is needed. Selection is informed by data trends, stakeholder input, and known gaps in care or service delivery. The current study focuses specifically on care management practices.

Activity 2: Define the Study Question(s)

Once the study topic is selected, the next step is to define specific research or evaluation questions. These questions clarify the study's purpose and establish what it aims to learn or improve. Well-defined questions ensure the study remains focused, measurable, and aligned with the broader goals of the quality strategy.

For studies focused on care management practices, MetaStar uses a review tool and guidelines developed in accordance with DHS contract requirements and DHS-provided care management training. The evaluation is structured around five key areas of care management:

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

These domains help shape the study questions and provide a framework for assessing performance and identifying opportunities for improvement.

Activity 3: Select the Study Variable(s)

After defining the study questions, the next step is to identify the key variables that will be measured to answer those questions**.** These variables may include clinical outcomes, service utilization, member satisfaction, or other indicators relevant to the study topic. Clearly defining each variable is essential to ensure consistent data collection, reliable analysis, and meaningful interpretation of results.

For studies evaluating care management practices, MetaStar's review tool outlines the specific variables to be measured for each review indicator. These indicators are designed to assess performance across five core areas of care management. This structured approach ensures that the evaluation is both targeted and aligned with contractual and training requirements.

Activity 4: Develop a Plan to Study the Population

This phase outlines how the target population will be identified and sampled for the review. It includes defining inclusion and exclusion criteria, determining sample size, and ensuring the selected population is representative of those affected by the topic under study. Members must be continuously enrolled for at least 60 days to be eligible for inclusion. Sample sizes are calculated to achieve a 90 percent confidence interval with a 5 percent margin of error.

In addition to the primary sample, MetaStar also reviews records of members previously identified in the prior year's review as having health and safety concerns or complex/challenging situations. These individual findings are shared with DHS and the MCO but are excluded from the current year's aggregate results.

Prior to the review, MetaStar reviews the MCO's policies and procedures to understand documentation practices and ensure alignment with review expectations.

Key planning and review activities include:

- Establishing review dates and duration
- Defining reviewer roles and team composition
- Developing a list of deliverables and associated timeframes
- Providing preparation guidance to the Managed Care Organization (MCO)

During the review, MetaStar maintains regular communication with the MCO and provides updates as needed to support coordination and transparency.

Activity 5: Collect Data

This review relies primarily on the examination of individual member records to evaluate the study variables. These records provide detailed insights into care management practices and outcomes. In addition to member records, supplementary data may be extracted from administrative systems or policy documents to support the review.

MetaStar utilizes a structured database modeled after the review tool to systematically collect and organize all relevant data. The review team is thoroughly trained, and inter-rater reliability is maintained to ensure consistency across reviewers. A comprehensive guidance document supports standardized data entry and interpretation, ensuring accuracy, completeness, and confidentiality throughout the data collection process.

Activity 6: Analyze and Interpret Study Results

In this phase, the collected data are analyzed to identify patterns, trends, and outcomes. The interpretation of results helps determine whether the study questions were answered and whether the findings indicate a need for improvement or confirm effective practices.

The review team gathers any additional information needed, compiles all data, and analyzes the results to assess MCO compliance with established benchmarks.

CMR compliance is reported in terms of a percentage score, a star rating that correlates with the *DHS Score Card*, and a compliance rating identified in the table below.

Score	Stars	Compliance Rating
95.0% - 100.0%	★★★★★	Fully Met

Score	Stars	Compliance Rating
90.0% - 94.9%	★★★★½	Fully Met
85.0% - 89.9%	★★★★	Substantially Met
80.0% - 84.5%	★★★½	Substantially Met
75.0% - 79.9%	★★★	Partially Met
70.0% - 74.9%	★★½	Partially Met
65.0% - 69.9%	★★	Minimally Met
60.0% - 64.9%	★½	Minimally Met
55.0%-59.9%	★	Not Met
< 54.9%	½	Not Met

To assess whether there has been a statistically significant change in rates year over year, MetaStar used a Pearson's Chi-Square Test of Independence. This test evaluated whether the distribution of responses or outcomes in one year differs from that in another, beyond what might be expected by random chance. It compared the observed frequencies in each category to the frequencies expected if there were no change over time. A significant result, typically $p < 0.05$, suggests that the differences in proportions across years are unlikely to be due to random variation alone.

The table below includes the symbols used to identify significant and non-significant changes. When change is significant, the symbols indicate the direction of change.

Statistical Change	Symbol
Increased	▲
Decreased	▼
No Significant Change	NS
Not Comparable	NC

Activity 7: Report Results to the State

The final step is to compile and communicate the study findings to the state. MetaStar submits a report outline, a final determination report, and any additional documentation requested by DHS, completing the review process.

If concerns arise regarding a member's immediate health and safety, or if complex or challenging circumstances are identified, MetaStar initiates the Quality Concern Protocol. Findings from this protocol are communicated directly to DHS and the MCO.

At the conclusion of the record review, MetaStar provides both DHS and the MCO with detailed findings from each individual record, along with a summary of the MCO's overall performance.

External Quality Review Protocol: Appendix A

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

Activity 1: MCO Completes the ISCA Tool

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. An ISCA tool is developed that the MCO completes, providing detailed information about its data systems and capabilities.

Activity 2: Perform Preliminary ISCA Review

The review team conducts a preliminary assessment of the submitted ISCA tool to identify areas requiring further clarification or follow-up. 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.

Activity 3: Onsite or Virtual Site Visit

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. The team engages with MCO staff to validate and expand upon the information provided.

Activity 4: Compile and Analyze ISCA Findings

The team compiles and analyzes the findings from the ISCA tool and site visit to assess the MCP's information system capabilities.

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. Compliance is reported in terms of a percentage score and a compliance rating identified in the table below.

Score	Compliance Rating
90.0% - 100.0%	Fully Met
80.0% - 89.9%	Substantially Met
70.0% - 79.9%	Partially Met
60.0% - 69.9%	Minimally Met
≤59.9%	Not Met

Activity 5: Draft ISCA Summary for EQR Technical Report

A summary of the ISCA findings is drafted for inclusion in the External Quality Review (EQR) technical report, ensuring that the results are clearly documented and communicated to the state.

Progress on Prior Recommendations

Each narrative report will include a section for progress on the prior year's EQRO recommendation. This section is a summary of the recommendations, actions taken by the MCO and degree to which the plan addressed the recommendations from the prior review. Progress is evaluated based on the number of recommendations addressed by the MCO in the current review.

Degree to which plans have addressed the previous year's EQRO recommendations key:

- **High** – All recommendations were addressed
- **Medium** – Half or more recommendations were addressed, but not all
- **Low** – No recommendations were addressed
- **N/A** – No recommendations received

External Quality Review Team

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 HEDIS®[2] auditor, and information technologies staff. 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 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.

Myers and Stauffer

The Myers and Stauffer EQR team consists of Certified Public Accountants (CPAs), project managers, data analysts, and specialists. The team is experienced with collecting and analyzing results for network adequacy validation under EQR Protocol 4. EQR team members have advanced degrees in analytics, statistics, engineering, and public policy. The team is also experienced in performing analyses for EQR Protocol 5 and Encounter Data Validation. Team members maintain their licensure and credentials through yearly training, which includes Generally Accepted Government Auditing Standards (GAGAS).

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

Appendix 2 – Performance Improvement Project Interventions and Effectiveness

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

Effectiveness	Description
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.
Not Implemented	MCO did not implement the strategy.

MCO	Topic	Clinical Improvement Strategies	Effectiveness
CCI	Diabetic Care	Provided targeted education to members with diabetes on the importance of annual eye exams.	Effective
*i*Care	Comprehensive Diabetes Care Family Care	Provided an evidence-based diabetes management learning program to nurse care managers.	Effective
*i*Care	Comprehensive Diabetes Care Family Care Partnership	Provided an evidence-based diabetes management learning program to nurse care managers.	Effective
LCI	Controlling Blood Pressure	Provided education and resources to RNCMs about blood pressure and cardiovascular disease.	Effective
MCW	Diabetic Care	Provided education and resources to members, including utilization of member materials with follow-up and repetition to members from the care management team.	Effective

MCO	Topic	Non-Clinical Improvement Strategies	Effectiveness
CCI	Member Satisfaction	Conducted an educational campaign to improve member access to MACs, targeting PACE members at Trinity Woods convent.	Effective
CCI	Member Satisfaction	Conducted an educational campaign to improve member access to MACs, targeting Spanish-speaking FC and FCP members.	Effective
*i*Care	Care Management Practices Family Care	Provided a detailed instructional training program on the use of the LTCFS Quality Review communication tool to IDT and their managers.	Effective
*i*Care	Caregiver Strain Family Care Partnership	Implemented the modified caregiver strain index assessment and standardized documentation for scoring.	Effective
LCI	Advance Directive Planning	Provided education and resources to CMs about advance directives.	Effective
LCI	Advance Directive Planning	Mailed reminder post cards to members who did not have APOA-HC paperwork scanned into their record.	Effective
MCW	Advance Care Planning	Provided targeted training to care team staff regarding advance directives.	Effective
MCW	Advance Care Planning	Reviewed, updated, and developed advance directive resources for members.	Effective

Appendix 3 – Performance Measure Validation Technical Definitions

Technical Definition 2024-2025
Percentage of Members Vaccinated for Influenza
Updated 09.30.2024

Title	**Influenza Vaccination Rate**
Description	This measure is used to assess the percentage of Family Care members who received an influenza immunization from July 1 to March 31.
Rationale	Refer to the most recent recommendations provided by the Centers for Disease Control and Prevention (CDC) and the CDC's Advisory Committee on Immunization Practices (ACIP). For additional information regarding the prevention and control of seasonal influenza and primary updates for 2024-2025 visit the CDC website.
Target Population	All members.
Numerator Description	Number of members in the denominator with evidence of a seasonal influenza vaccine given from July 1 to March 31.
Numerator Exclusions	None
Denominator Description	Number of members continuously enrolled from July 1 to March 31.
Denominator Inclusions/Exclusions	**INCLUSIONS** • **Regarding vaccination of:** PERSONS WITH EGG ALLERGY Refer to CDC and ACIP guidance. **The member is to be included in the denominator.** **EXCLUSIONS** *Source:* Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP)—United States, 2024–25, Summary of Recommendations. **Contraindications:** See Table 3, in the *Source* linked above in this section, for 2024-2025 influenza contraindications and precautions specifications.

Title	Influenza Vaccination Rate
	See Table 4, in the *Source* linked above in this section, for influenza vaccine contraindications and precautions for persons with a history of severe allergic reaction to influenza vaccine. **NOTE:** • Any other contraindication(s), precaution(s), or reason(s) stated by a member for not obtaining the influenza vaccine should be documented in the member record but, is **not** an acceptable contraindication or precaution for the purposes of data collection for this measure. • If a prescribing health care provider defers a vaccination based on a precaution, the precaution is to be counted as a contraindication. **Contraindication & Precaution:** See CDC's Tables 3 and 4: Influenza Vaccine Contraindications and Precautions.
Data Source	Any evidence source, including member service records, Wisconsin Immunization Registry (WIR), self-report, or other documentation.
Interpretation of Score	Desired value is a higher score.

Technical Definition 2024–2025
Percentage of Members Vaccinated for Pneumonia
Updated 09.30.2024

Title	Pneumococcal Vaccination Rate
Description	This measure assesses the percentage of members age 65 and older who have *ever* received a pneumococcal immunization.
Rationale	Refer to the most recent recommendations provided by the Centers for Disease Control and Prevention (CDC) and the CDC's Advisory Committee on Immunization Practices (ACIP). Refer to CDC's Pneumococcal Vaccine Recommendations for additional information.
Target Population Age	All members age 65 and older as of July 1 of the measurement year.

Numerator Description	The number of members in the denominator with documentation of ever having been given a pneumococcal vaccine. Include any pneumococcal immunization encounter for each member. **NOTE:** • Over time, different pneumococcal vaccines have been available: PCV13 (Prevnar), 15-valent PCV (PCV15), 20-valent pneumococcal conjugate vaccine (PCV20) and 23-valent pneumococcal polysaccharide vaccine (PPSV23, Pneumovax 23). The ACIP has reviewed and modified its recommendations for administration of the pneumococcal vaccine accordingly. • For purposes of this measure, any pneumococcal immunization encounter (by a member in the denominator) with any pneumococcal vaccine type counts in the numerator. It is noted that a member may receive more than one pneumococcal vaccine in a lifetime. At a minimum, any one pneumococcal immunization encounter counts in the numerator.
Numerator Exclusions	None
Denominator Description	Total number of members aged 65 and older continuously enrolled from July 1 to December 31 of the measurement year.
Denominator Exclusions	*Source:* ACIP Contraindications Guidelines for Immunization | CDC**.** **Contraindications:** See tables 4.1 and 4.2 in the *Source* linked above in this section. **NOTE:** A history of invasive pneumococcal disease or pneumonia is incorrectly perceived as a contraindication or precaution to PPSV23 vaccination (i.e., vaccines may be given under these conditions) **Precautions:** See table 4.1 in the *Source* linked above in this section. **NOTE:** • Any other contraindication(s), precaution(s) or reason(s) stated by a member for not obtaining the pneumococcal vaccine should be documented in the member record but is **not** an acceptable contraindication or precaution for the purposes of data collection for this measure. • If a prescribing health care provider defers a vaccination on the basis of a precaution, the precaution is to be counted as a contraindication.

	Contraindication & Precaution: See CDC's Tables 4-1 and 4-2: Contraindications and Precautions.
Data Source	Any evidence source, including member service records, Wisconsin Immunization Registry (WIR), self-report, or other documentation.
Interpretation of Score	Desired value is a higher score.
Additional information	1. **Centers for Disease Control and Prevention** (September 2024) Pneumococcal vaccine timing for adults (table format) 2. **National Foundation of Infectious Diseases** (July 2024) Pneumococcal Disease 3. **Immunize.org** (August 2024) Ask the Experts: Pneumococcal 4. **Report a vaccine adverse event** to the Vaccine Adverse Event Reporting System (VAERS) (hhs.gov)

Appendix 4 – Compliance with Standards – Statewide and MCO Level Results

The tables below display the results from the standards reviewed in the FY 23-24 review at the state and MCO level.

State Level Compliance with Standards Results – QAPI Standards

Standard	Scoring Elements	Percentage	Stars	Compliance Rating
Q1: General rules - 42 CFR 438.330(a)	38/40	95.0%	★★★★★	Fully Met
Q2: Basic elements of the quality assessment and performance improvement program - 42 CFR 438.330(b)	36/40	90.0%	★★★★½	Fully Met
Q3: Performance measurement - 42 CFR 438.330(c)	N/A	N/A	N/A	N/A
Q4: Performance improvement projects - 42 CFR 438.330(d)	N/A	N/A	N/A	N/A
Q5: QAPI evaluations review - 42 CFR 438.330(e)(2)	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.

State Level Compliance with Standards Results – Grievance Systems Standards

Standard	Scoring Elements	Percentage	Stars	Compliance Rating
G1: Grievance systems - 42 CFR 438.228	20/20	100.0%	★★★★★	Fully Met
G2: General requirements - 42 CFR 438.402	35/35	100.0%	★★★★★	Fully Met
G3: Timely and adequate notice of adverse benefit determination - 42 CFR 438.404	13/20	65.0%	★★	Minimally Met
G4: Handling of grievances and appeals - 42 CFR 438.406	44/45	97.8%	★★★★★	Fully Met
G5: Resolution and notification - 42 CFR 438.408	34/35	97.1%	★★★★★	Fully Met
G6: Expedited resolution of appeals - 42 CFR 438.410	20/20	100.0%	★★★★★	Fully Met
G7: Information about grievance and appeal system to providers and subcontractors - 42 CFR 438.414	10/10	100.0%	★★★★★	Fully Met

Standard	Scoring Elements	Percentage	Stars	Compliance Rating
G8: Record keeping requirements - 42 CFR 438.416	5/5	100.0%	★★★★★	Fully Met
G9: Continuation of benefits while the local appeal and the state Fair Hearing are pending - 42 CFR 438.420	20/20	100.0%	★★★★★	Fully Met
G10: Effectuation of reversed appeal resolution - 42 CFR 438.424	13/13	100.0%	★★★★★	Fully Met
Overall	**214/223**	**96.0%**	★★★★★	**Fully Met**

MCO Compliance with Standards Comparison Results – QAPI Standards

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

*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.

MCO Compliance with Standards Comparison Results – Grievance Systems Standards

Standard	CCI	*i*Care	LCI	MCW
G1: Grievance systems - 42 CFR 438.228	100.0%	100.0%	100.0%	100.0%
G2: General requirements - 42 CFR 438.402	100.0%	100.0%	100.0%	100.0%
G3: Timely and adequate notice of adverse benefit determination - 42 CFR 438.404	50.0%	75.0%	75.0%	75.0%
G4: Handling of grievances and appeals - 42 CFR 438.406	100.0%	100.0%	100.0%	100.0%
G5: Resolution and notification - 42 CFR 438.408	100%	100.0%	100.0%	85.7%
G6: Expedited resolution of appeals - 42 CFR 438.410	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%

Standard	CCI	*i*Care	LCI	MCW
G8: Record keeping requirements - 42 CFR 438.416	100.0%	100.0%	100.0%	100.0%
G9: Continuation of benefits while the local appeal and the state Fair Hearing are pending - 42 CFR 438.420	100.0%	100.0%	100.0%	100.0%
G10: Effectuation of reversed appeal resolution - 42 CFR 438.424	100.0%	100.0%	100.0%	100.0%
Overall	**95.6%**	**97.7%**	**97.8%**	**95.5%**

Appendix 5 – Network Adequacy Validation – Statewide Service Type Results

Service Type Results Statewide				
Program	Service Type	Target Met	Total	Percent Met
FC	Adult Day Care	9	13	69.2%
FC	Adult day care services	84	94	89.4%
FC	Adult residential care – 1- 2 bed adult family homes	135	149	90.6%
FC	Adult residential care – 3- 4 bed adult family homes	134	146	91.8%
FC	Adult residential care - community-based residential facility	121	121	100.0%
FC	Adult residential care - residential care apartment complex	96	102	94.1%
FC	Alcohol and Other Drug Abuse Day Treatment Services	22	30	73.3%
FC	AODA day treatment	38	41	92.7%
FC	AODA services (excluding inpatient or physician provided)	122	127	96.1%
FC	Consumer-directed supports (self-directed supports) broker	166	196	84.7%
FC	Counseling and Therapeutic Resources	139	140	99.3%
FC	Daily living skills training	245	249	98.4%
FC	Financial Management Services	170	172	98.8%
FC	Home health services	139	141	98.6%
FC	Home-delivered meals	142	142	100.0%
FC	Mental Health Day Treatment Services (in all settings)	55	79	69.6%
FC	Mental health services (excluding inpatient, physician-provided, or comprehensive community services)	127	127	100.0%
FC	Nursing (including intermittent and private duty)	101	101	100.0%
FC	Nursing Home	15	15	100.0%
FC	Nursing home stays (nursing home, institute for mental disease, and intermediate care facility for individuals with intellectual disabilities)	127	127	100.0%
FC	Occupational Therapy	108	120	90.0%
FC	Personal Care	103	103	100.0%
FC	Physical Therapy	130	132	98.5%
FC	Prevocational Services	105	120	87.5%

Service Type Results Statewide				
Program	Service Type	Target Met	Total	Percent Met
FC	Respiratory care	36	37	97.3%
FC	Respite Care	140	140	100.0%
FC	Self-directed personal care	132	134	98.5%
FC	Skilled Nursing Services	17	19	89.5%
FC	Speech & Language Pathology Services	111	123	90.2%
FC	Supported Employment	231	261	88.5%
FC	Supportive Home Care / Assist with ADLs	57	60	95.0%
FC	Transportation (excluding ambulance)	104	112	92.9%
FC	Transportation (specialized transportation) - other transportation	68	69	98.6%
FC	Transportation (specialized transportation) – other transportation	45	49	91.8%
FCP	Adult Day Care	9	9	100.0%
FCP	Adult day care services	13	13	100.0%
FCP	Adult residential care – 1- 2 bed adult family homes	30	30	100.0%
FCP	Adult residential care – 3- 4 bed adult family homes	30	30	100.0%
FCP	Adult residential care - community-based residential facility	13	13	100.0%
FCP	Adult residential care - residential care apartment complex	10	12	83.3%
FCP	Alcohol and Other Drug Abuse Day Treatment Services	9	9	100.0%
FCP	Alcohol and Other Drug Abuse Services	9	9	100.0%
FCP	AODA day treatment	12	13	92.3%
FCP	AODA services (excluding inpatient or physician provided)	13	13	100.0%
FCP	Community Support Program	22	22	100.0%
FCP	Consumer-directed supports (self-directed supports) broker	13	13	100.0%
FCP	Counseling and Therapeutic Resources	20	21	95.2%
FCP	Daily living skills training	13	13	100.0%
FCP	Day habilitation services	13	13	100.0%
FCP	Financial Management Services	22	22	100.0%
FCP	Habilitation Services: Daily Living Skills Training	9	9	100.0%
FCP	Habilitation Services: Day Habilitation Services	9	9	100.0%
FCP	Home Health	9	9	100.0%

Service Type Results Statewide				
Program	Service Type	Target Met	Total	Percent Met
FCP	Home health services	13	13	100.0%
FCP	Home-delivered meals	22	22	100.0%
FCP	Mental health Day Treatment	12	12	100.0%
FCP	Mental Health Day Treatment Services (in all settings)	8	9	88.9%
FCP	Mental Health Services	9	9	100.0%
FCP	Mental health services (excluding inpatient, physician-provided, or comprehensive community services)	13	13	100.0%
FCP	Nursing (including intermittent and private duty)	13	13	100.0%
FCP	Nursing Home	9	9	100.0%
FCP	Nursing home stays (nursing home, institute for mental disease, and intermediate care facility for individuals with intellectual disabilities)	13	13	100.0%
FCP	Occupational Therapy	22	22	100.0%
FCP	Personal Care	14	14	100.0%
FCP	Physical Therapy	22	22	100.0%
FCP	Prevocational Services	21	22	95.5%
FCP	Respiratory care	13	13	100.0%
FCP	Respite Care	22	22	100.0%
FCP	Self-directed personal care	31	31	100.0%
FCP	Skilled Nursing Services	14	14	100.0%
FCP	Speech & Language Pathology Services	22	22	100.0%
FCP	Supported Employment	34	35	97.1%
FCP	Supportive Home Care / Assist with ADLs	36	36	100.0%
FCP	Transportation (excluding ambulance)	19	22	86.4%
FCP	Transportation (specialized transportation) – other transportation	7	8	87.5%
PACE	Adult Day Care	4	4	100.0%
PACE	Adult residential care – 1- 2 bed adult family homes	8	8	100.0%
PACE	Adult residential care – 3- 4 bed adult family homes	8	8	100.0%
PACE	Alcohol and Other Drug Abuse Day Treatment Services	4	4	100.0%
PACE	Alcohol and Other Drug Abuse Services	4	4	100.0%

Service Type Results Statewide				
Program	Service Type	Target Met	Total	Percent Met
PACE	Community Support Program	4	4	100.0%
PACE	Counseling and Therapeutic Resources	4	4	100.0%
PACE	Financial Management Services	4	4	100.0%
PACE	Habilitation Services: Daily Living Skills Training	4	4	100.0%
PACE	Habilitation Services: Day Habilitation Services	4	4	100.0%
PACE	Home Health	4	4	100.0%
PACE	Home-delivered meals	4	4	100.0%
PACE	Mental Health Day Treatment Services (in all settings)	4	4	100.0%
PACE	Mental Health Services	4	4	100.0%
PACE	Nursing Home	4	4	100.0%
PACE	Occupational Therapy	4	4	100.0%
PACE	Personal Care	4	4	100.0%
PACE	Physical Therapy	4	4	100.0%
PACE	Prevocational Services	4	4	100.0%
PACE	Respite Care	4	4	100.0%
PACE	Self-directed personal care	8	8	100.0%
PACE	Skilled Nursing Services	4	4	100.0%
PACE	Speech & Language Pathology Services	4	4	100.0%
PACE	Supported Employment	4	4	100.0%
PACE	Supportive Home Care / Assist with ADLs	16	16	100.0%
PACE	Transportation (excluding ambulance)	4	4	100.0%