MetaStar

External Quality Review

Calendar Year 2025

Prepared for

Wisconsin Department of Health Services

Division of Medicaid Services

Annual Technical Report

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

In partnership with

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Final Report: April 13, 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 Complexities 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.

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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
AIDS	Acquired Immunodeficiency Syndrome
ADL	Activity of Daily Living
ADR	Accreditation Desk Review
AMR	Asthma Medication Ratio
Anthem	Anthem Blue Cross and Blue Shield Health Plan
AODA	Alcohol and Other Drug Abuse
ACT	Annual Compliance Tool
ASL	American Sign Language
BC+	BadgerCare Plus
BCS-E	Breast Cancer Screening
BQO	Bureau of Quality Oversight
C4K	Care4Kids
CBP	Controlling Blood Pressure
CCHP	Chorus Community Health Plan, Inc.
CCS	Cervical Cancer Screening
CDCP	Certified Direct Care Professional
CFR	Code of Federal Regulations
CAHPS®	Consumer Assessment for Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CIS	Childhood Immunization Status
CCF	Children Come First
CLAS	Culturally and Linguistically Appropriate Services
CMC	Children with Medical Complexity
CMR	Care Management Review
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
C-Section	Caesarean Section
CY	Calendar Year
DHA	Division of Hearings and Appeals
DHP	Dean Health Plan, Inc.
DHS	Wisconsin Department of Health Services
DMS	Division of Medicaid Services
EHR	Electronic Health Record
EQR	External Quality Review
EQRO	External Quality Review Organization
ESRI	Environmental Systems Research Institute, Inc.

Acronym	Description
FAR	Final Audit Report
FC	Family Care
FCMH	Foster Care Medical Home
FCP	Family Care Partnership
FFS	Fee For Service
FUH	Follow-Up After Hospitalization for Mental Illness
FUM	Follow-Up After Emergency Department Visit for Mental Illness
GAGAS	Generally Accepted Government Auditing Standards
GHC-EC	Group Health Cooperative of Eau Claire
GHC-SCW	Group Health Cooperative of South Central Wisconsin
GSD	Glycemic Status Assessment for Patients with Diabetes
HBD	Hemoglobin A1C Control for Patients with Diabetes - HBA1 Control
HCBS	Home and Community Based Services
[1]HEDIS®	Healthcare Effectiveness Data and Information Set
HEDIS® LO	Healthcare Effectiveness Data and Information Set Licensed Organization
HiB	Haemophilus Influenza type B Vaccine
HIV	Human Immunodeficiency Virus
HFN	HMO Facilities Network
HPN	HMO Provider Network
HMO	Health Maintenance Organization, also known as a Managed Care Organization
HPV	Human Papillomavirus Vaccine
HNA	Health Needs Assessment
IADL	Instrumental Activity of Daily Living
*i*Care	Independent Care Health Plan
IMA	Immunizations for Adolescents
ISCA	Information Systems Capabilities Assessment
LSC	Lead Screening in Children
MA	Medicaid
MAPP	Medicaid Purchase Plan
MCHP	MercyCare Health Plan
MCO	Managed Care Organization
MHS	MHS Health Wisconsin
MHWI	Molina Healthcare of Wisconsin, Inc.
MMIS	Medicaid Management Information System
N/A	Not Applicable

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

Acronym	Description
NCQA	National Committee for Quality Assurance
NHP	Network Health Plan
NPI	National Provider Identifier
OB/GYN	Obstetrician Gynecologist
OBMH	OB Medical Home
OHC	Out of Home Care
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary Care Physician and Primary Care Provider
PDSA	Plan-Do-Study-Act
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PPC	Prenatal and Postpartum Care
PMV	Performance Measure Validation
PPL	Parental Payment Liability
POC	Point of Care
QA	Quality Assurance
QAPI	Quality Assessment and Performance Improvement
Q-PASS	Quality Performance Assessment Support System
QTT	Qualified Treatment Trainee
Quartz	Quartz Health Solutions, Inc.
SAC	Substance Abuse Counselor
SAM	System for Award Management
SHP	Security Health Plan of Wisconsin
SDoH	Social Determinants of Health
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
SSI	Supplemental Security Income
SUD	Substance Use Disorder
TDD	Telecommunications Device for the Deaf
TTY	Teletypewriter
UHC	UnitedHealthcare Community Plan
WCV	Well-Child Visits
WICT	Wisconsin Interdisciplinary Care Team
WM	Wraparound Milwaukee

Executive Summary

Purpose and Overview of Report

The CFR at 42 CFR § 438 requires states that operate MCOs and PIHPs to provide 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 as well as a record review of a targeted care management benefit provided Fee-for-Service to children and youth with medical complexity.

This report summarizes the findings from the CY 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

For purposes of this report, the term MCO is used to refer to all managed care entities evaluated. When the organization type is specific to a PIHP, this will be explicitly identified.

Wisconsin Medicaid Overview

Wisconsin Medicaid began delivering services through a managed care model in the mid-1980s, initially focused on acute care needs. Over time, the program expanded to serve individuals with special health care needs, including those with disabilities and those eligible for Supplemental Security Income. By the early 2000s, managed care had been implemented statewide.

Today, Wisconsin offers several Medicaid managed care programs operated by multiple organizations across the state. These programs support the acute, primary, and behavioral health needs of both adults and children. One program serves adults exclusively, while another includes both adults and children and functions as the state's Children's Health Insurance Program.

Additional programs have been developed to provide long-term services and supports for adults with developmental and physical disabilities, as well as for older adults. Across all programs, Wisconsin Medicaid aims to improve access to care, enhance member choice, and promote health equity.

State Quality Strategy Evaluation

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

The 2025–2027 Wisconsin Medicaid Managed Care Quality Strategy is built around three primary goals, each supported by specific objectives and methods for improvement[2]:

Goal 1: Improve Member Health and Social Connectedness
The focus of this goal is on achieving better clinical outcomes and ensuring members are socially integrated.

- HEDIS® Performance: Increasing the number of Medicaid HEDIS® measures that meet or exceed the national median, 50th percentile, by 2027.

[2] *Information sourced from the Wisconsin Department of Health Services Medicaid Managed Care Quality Strategy 2025-2027*

- Chronic Condition Management: Targeting the 75th percentile nationally for chronic health measures, specifically focusing on asthma for children and diabetes and hypertension for adults.
- Preventive Care: Restoring pre-pandemic levels of primary care utilization and increasing screenings for lead poisoning, colon cancer, and breast cancer.
- Behavioral Health: Prioritizing access to outpatient, least-restrictive behavioral health and substance use disorder services to decrease the need for inpatient stays.
- Workforce Development: Training 10,000 individuals as Certified Direct Care Professionals by 2027 to improve member health and safety through better care capacity.

Goal 2: Reduce Health Disparities and Support Underserved Populations

This goal aims to improve health equity by addressing the social determinants of health.

- Health-Related Social Needs: Ensuring members identified with needs in food, housing, or transportation receive a corresponding intervention within 30 days of screening.
- Maternal and Birth Outcomes: Reducing racial and ethnic disparities in low birth weights and C-section rates. It specifically aims to reduce the low-birth-weight rate for African American or Black populations to match that of White populations by 2027.
- Data Stratification: Increasing the use of member demographics, such as race, ethnicity, sex, geography, in performance reporting to better identify and target specific health gaps.
- Out-of-Home Care (Care4Kids): Prioritizing timely health screens and comprehensive assessments for children entering out-of-home care.

Goal 3: Support Quality Improvement through Compliance

This goal ensures the integrity of programs through rigorous oversight and adherence to federal and state benchmarks.

- Network Adequacy: Requiring managed care plans to maintain at least 90 percent compliance with standards for provider time, distance, and member-to-provider ratios.
- Annual Compliance Tool: Using the ACT to monitor contract requirements, with a target for plans to achieve a compliance score of at least 80 percent.
- Provider Participation: Working to maintain or increase participation among key provider types, particularly in rural areas or sectors impacted by workforce shortages.

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.

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.

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. The table below summarizes the evaluation of each quality strategy outlined in Wisconsin's 2025-2027 Medicaid Managed Care Quality Strategy.

Evaluation of Quality, Timeliness, and Access

This Annual Technical Report demonstrates how Wisconsin's EQR activities align with the State's Quality Strategy, as required by federal regulation, 42 CFR § 438.340. The Quality Strategy serves as a framework for improving the quality, timeliness, and access to care provided by Medicaid Managed Care Organizations.

During the review period, the State advanced its strategy by conducting federally mandated EQR activities, including validating performance improvement projects, performance measures, compliance reviews, and network adequacy. Findings from reviews were used to refine oversight priorities and update the strategy itself. Collaboration with MCOs ensured that quality initiatives remained data-driven and strategically focused.

The report evaluates the impact of these efforts, highlighting improvements in chronic disease management, maternal health, behavioral health access, and timely prenatal and postpartum care. Accountability measures included corrective action plans for underperforming MCOs, technical assistance, and public transparency through online publication of reports.

Where appropriate, the State substituted certain EQR activities with comparable Medicare or accreditation reviews, ensuring continued alignment with the Quality Strategy.

Summary of EQR Activities and Recommendations

MetaStar conducted Wisconsin's 2025 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. State-level findings highlight strengths, opportunities for improvement, and recommendations. Additionally, the review activities support various components of the State's Medicaid Managed Care Quality Strategy 2025-2027, 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 services that are consistent with current professional, evidence-based knowledge, and (3) interventions for performance improvement.
- Timeliness: Reducing wait and sometimes harmful delays, and is interrelated with safety, efficiency, and member-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 availability and timeliness elements.

Table 1. State Quality Strategy Evaluation - Quality

Quality – Outcomes and Evidenced-Based Care
Structural Characteristics: The strategy uses the Annual Compliance Tool and External Quality Review results to ensure managed care plans have the operational structures required by 42 CFR § 438.330.
Strengths: • The MCOs demonstrated a robust quality framework by integrating rigorous, evidence-based methodologies into their clinical PIPs. Through detailed member research, precise population identification, and the use of valid data collection and analysis techniques, the MCOs ensured that structural compliance translated into measurable, data-driven interventions likely to improve member outcomes (Protocol 1). • MCOs implemented structured policies to ensure timely access to care and maintained oversight frameworks with routine monitoring and corrective action processes to ensure provider adherence (Protocol 3). • The organizations supported delivery of culturally competent services by embedding the National CLAS Standards into operations, promoting these standards among providers, and maintaining a diverse network capable of meeting linguistic and cultural needs (Protocol 3). • MCOs maintained comprehensive, consistently applied policies governing service authorizations, aligned with contractual and federal requirements. Processes ensure services were authorized based on necessity and delivered in appropriate amount, duration, and scope (Protocol 3). • Accessible, culturally appropriate communication was ensured through the provision of materials in prevalent non-English languages, oral interpretation, auxiliary aids, and accessible electronic materials (Protocol 3). • MCOs ensured members received comprehensive information on treatment options in a manner suited to their understanding. Providers were not restricted from advising or advocating within their lawful scope regarding treatment options, risks, benefits, or the member's right to participate in or refuse treatment (Protocol 3). • Robust credentialing and recredentialing structures aligned with state and federal requirements. The MCOs enforced non-discrimination, ensured licensure and accreditation, and prohibited contracting with excluded providers (Protocol 3).
Recommendations: • Restructure non-clinical aim statements to be concise and strategically focused, eliminating extraneous information to clearly define target populations and specific improvement mechanisms. Each project must incorporate measurable numeric benchmarks and fixed timeframes to ensure objective progress tracking, accountability, and a clear foundation for driving results (Protocol 1). • MCOs must transition from passive HEDIS® reporting to a proactive, validated measurement framework. This requires implementing rigorous internal audit controls and standardized data integration systems to ensure all HEDIS-aligned measures are accurate, transparent, and fully supported by verifiable documentation. Furthermore, MCOs should establish a formal corrective action loop to analyze and resolve technical data barriers, ensuring that future HEDIS submissions meet all NCQA standards and regulatory validation criteria (Protocol 2). • Formalize protocols to guarantee member access to second opinions and out-of-network providers, when necessary, alongside implementing rigorous documentation standards for the timely delivery of high-risk prenatal care (Protocol 3).

Quality – Outcomes and Evidenced-Based Care
• Establish a structured data-sharing process to exchange assessment information with other MCOs to eliminate service duplication. This must include implementing member-level needs stratification and developing individualized care plans specifically for members with special health care needs. • Refine disenrollment processes to ensure all actions are accurate, timely, and member-driven, directly reflecting the regulatory mandate to protect member rights and choice (Protocol 3). • Revise payment and utilization policies to guarantee that members are not held liable for emergency services and that stabilization protocols for transfer or discharge strictly adhere to federal clinical safety mandates (Protocol 3). • Develop or update written policies for physical restraints and advance directives to incorporate all current state and federal regulations, ensuring these documents are integrated into the MCO's formal quality compliance reviews (Protocol 3). • Formalize the development, adoption, and dissemination of clinical practice guidelines. This requires implementing a verifiable documentation process that confirms guidelines are reviewed periodically, consistently integrated into all utilization management decision-making, and proactively distributed to the provider network. Furthermore, MCOs must ensure transparency by establishing clear, accessible channels for both members and potential members to obtain these guidelines upon request (Protocol 3).
HEDIS® Performance: Increasing the number of HEDIS® measures in Adult and Child Core Sets that meet or exceed the national HEDIS® 50th percentile as published in the Quality Compass® (Protocol 2).
Strengths: The state-level findings for the following Adult and Child Core Set HEDIS® Measure rates met or exceeded the national HEDIS® 50th percentile as published in the Quality Compass®: • Lead Screening in Children (LSC) – BC+ program • Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC) – BC+ program • Prenatal and Postpartum Care – Postpartum Care (PPC) – BC+ program • Glycemic Status Assessment for Patients with Diabetes <8.0 percent (GSD) – BC+ and SSI programs • Controlling Blood Pressure (CBP) – BC+ program • Follow-Up within 30 Days After Hospitalization for Mental Illness – 30 Day Total (FUH) – BC+ and SSI programs • Breast Cancer Screening (BCS-E) – SSI program • Cervical Cancer Screening (CCS) – SSI program

Recommendations:
• CIS, IMA, and WCV:
  ○ Implement value-added member engagement programs or small incentives to encourage the completion of age-appropriate wellness visits and vaccinations.
  ○ Provide clinical teams with frequent "gap-to-goal" lists to prioritize scheduling for pediatric and adolescent members approaching key age milestones.
• AMR - Total:
  ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence.
  ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management.
• FUM:

Quality – Outcomes and Evidenced-Based Care
○ Expand the use of telehealth for post-discharge follow-up visits to mitigate common barriers such as transportation and scheduling conflicts. ○ Enhance notification systems for emergency department and inpatient discharges to ensure care managers can coordinate the required seven-day follow-up window. • SSD: ○ Support behavioral health providers in performing or coordinating metabolic screenings (Glucose or A1c) during routine psychiatric visits. ○ Improve the bidirectional sharing of laboratory results between primary care and behavioral health providers to ensure comprehensive monitoring and reduce duplicate testing.
Clinical Outcomes: Targeting the national HEDIS® 75th percentile for chronic conditions like asthma, diabetes, and hypertension, as published in the Quality Compass®(Protocol 2).
Strengths: None identified.
Recommendations: • AMR – Total: ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence. ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management. • GSD <8 percent: ○ Support the use of rapid in-office screening tools to ensure immediate clinical results and data capture, reducing reliance on external laboratory follow-ups. ○ Expand screening opportunities during routine clinical and pharmacy interactions to create low-barrier access for members. ○ Utilize clinical support staff to conduct medication reviews and regimen adjustments for members trending above the 8.0 percent threshold. • SSD: ○ Support behavioral health providers in performing or coordinating metabolic screenings (Glucose or A1c) during routine psychiatric visits. ○ Improve the bidirectional sharing of laboratory results between primary care and behavioral health providers to ensure comprehensive monitoring and reduce duplicate testing.

Table 2. State Quality Strategy Evaluation - Access

Access - Availability and Service Use
Network Adequacy: Maintaining at least 90 percent compliance with time, distance, and provider-to-member ratio standards (Protocol 4).
Strengths: According to the DHS Network Adequacy Compliance Letters, the MCOs successfully secured "Approval" status across the majority of their service areas, confirming that their operational structures effectively support member access to care. This achievement reflects a mature network management strategy capable of meeting rigorous state and federal benchmarks for geographic and numerical adequacy.
Recommendations:

Access - Availability and Service Use
MCOs must remediate network adequacy deficiencies by addressing drive time and distance gaps, member-to-provider ratios, and appointment availability standards. Specifically, MCOs should implement a targeted corrective action plan to resolve "Approval with Conditions," "Denied," or "Decertified" county statuses and improve appointment wait times, which currently meet the 15-business day standard only 43.6 percent of the time. This remediation must include verifying provider participation status, ensuring networks are accepting new members, and removing administrative barriers, such as premature personal information requirements, that prevent members from securing timely access to care.
Specialized Access: For the Care4Kids program, access is defined by the immediate identification of medical, dental, and mental health needs within 48 hours of a child entering out-of-home care (Protocol 9).
Strengths: • The C4K program demonstrated exceptional structural performance, with 100 percent of completed out-of-home care screens meeting comprehensive screening standards. By successfully screening all records to identify both immediate medical needs and necessary follow-up care prior to comprehensive assessments, the PIHP ensured a highly responsive specialized access framework.
Recommendations: • The C4K program must significantly improve the timeliness of OHC health screenings. The MCO should conduct a root-cause analysis to identify systemic barriers, such as delays in placement notification or provider capacity, and implement a formal corrective action plan to ensure children entering out-of-home care receive immediate medical, dental, and mental health assessments. Strengthening the coordination between child welfare agencies and the provider network is essential to bridge this performance gap and ensure the health and safety of this vulnerable population.

Table 3. State Quality Strategy Evaluation - Timeliness

Timeliness - Reducing Delays
Mental Health Interventions: Increasing timely follow-up care after an emergency department visit or inpatient stay for mental health disorders (Protocol 2).
Strengths: None identified.
Recommendations: • Prioritize telehealth appointments for follow-up visits after an emergency department visit or inpatient stay for mental health disorders. HEDIS® allows for tele-behavioral health, which significantly reduces the 7-day no-show rate caused by transportation barriers. • Integration with Admission, Discharge, Transfer feeds is critical for the HEDIS® FUH and FUM measures. Care managers should be alerted within 24 hours of an ED discharge to facilitate the 7-day follow-up window.
Care Transitions: The plans aim to increase the percentage of SSI members who receive transition care within five days following a hospitalization (Protocol 9).
Strengths: None identified.
Recommendations: • Contact members for follow-up after inpatient hospital discharge, within five business days.

Timeliness - Reducing Delays
• Ensure all post-hospitalization follow-up includes medication reconciliation, assessment of the member's ability to manage medications, and support in understanding their treatment plan, medication schedule, and condition management.
Care4Kids Screens: Completing health screens within two days of enrollment and comprehensive assessments within 30 days (Protocol 9).
Strengths: None identified.
Recommendations: • Develop a process and tracking mechanism to ensure OHC Health Screens and initial comprehensive health assessments are conducted timely.

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 4: PIP Summary of Findings and Recommendations – State Level

State Level
Strengths
• The MCOs conducted and reported detailed research regarding the topic selection and importance to members. • The MCOs clearly identified the clinical PIP populations in relation to the aim statements. • The MCOs selected clinical PIP variables and performance measures that were clear indicators of performance. • The MCOs used valid and reliable procedures to collect PIP data and inform measurements. • The MCOs used appropriate techniques to analyze clinical PIP data and interpret results. • The MCOs selected and implemented appropriate, evidence-based interventions that were likely to lead to desired improvements in the clinical PIPs.
Weaknesses/Opportunities for Improvement
• Lack of Specificity and Strategic Clarity (Scoring Elements 2.1 and 2.2): Multiple clinical and non-clinical aim statements failed to define the target population and the specific improvement strategies to be used. This lack of precision creates ambiguity regarding who the project serves and the exact mechanisms intended to drive change. • Absence of Time-Bound and Measurable Metrics (Scoring Elements 2.3 and 2.6): Several projects lacked quantifiable components and defined timeframes. Without numeric targets or specific deadlines, the projects cannot objectively track progress, demonstrate success, or ensure accountability for results. • Poor Structural Design and Clarity (Scoring Elements 2.4 and 2.5): A significant number of aim statements were either not answerable or lacked conciseness. The inclusion of extraneous

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information and the absence of a clear, focused goal prevented these statements from serving as effective foundational guides for the PIPs. • Inconsistent Alignment Between Project Populations and Research Questions (Scoring Element 3.1): Two non-clinical projects failed to establish clear parameters for their target populations in relation to the core PIP question. This lack of definition created a misalignment between the improvement goals and the groups being measured, making it difficult to validate the relevance of the data sets used. • Inadequate Variable Selection (Scoring Element 5.1): Eight non-clinical projects failed to identify a complete set of variables necessary to answer their core PIP questions. The omission of key metrics and a lack of alignment between variables and project goals prevented these initiatives from capturing the data depth required for a comprehensive evaluation. • Deficiencies in Longitudinal Performance Tracking (Scoring Element 5.5): Two projects lacked consistent longitudinal tracking, limiting their ability to compare performance over time. This gap hindered the use of data-driven insights to evaluate the effectiveness of quality improvement activities and track progress toward long-term goals. • Absence of Inter-Rater Reliability Protocols (Scoring Element 5.9): Half of the applicable projects lacked a formalized strategy to ensure inter-rater reliability. Without standardized protocols for data collection, these projects face an increased risk of subjectivity and inconsistency between different evaluators, potentially compromising the validity of the results. • Inconsistent Outcome Measurement and Validation (Scoring Elements 7.2 and 7.3): Several projects failed to establish both baseline and repeat measurements, making it impossible to objectively evaluate progress. Furthermore, three projects lacked statistical significance testing, leaving a gap in mathematical evidence to prove that changes were driven by the intervention rather than random chance. • Lack of Comparative Depth (Scoring Element 7.6): Three projects failed to compare results across multiple entities or subgroups. By restricting analysis to a single, aggregate data set, these projects were unable to identify critical performance variations across different provider sites, populations, or organizations. • Ineffective Data Communication (Scoring Element 7.7): Five projects did not meet standards for concise and accessible reporting. Results were presented in a complex manner that obscured key insights, hindering the ability of stakeholders to quickly interpret the findings or assess the overall impact of the PIP. • Lack of Evidence-Based Foundation (Scoring Element 8.1): Five projects failed to demonstrate that their chosen improvement strategies were grounded in established research or prior data. Without a documented evidence base, there was no clear logical link to suggest the selected interventions would lead to the desired process or outcome improvements. • Inconsistent Use of Iterative Testing (Scoring Element 8.3): Several projects bypassed the rapid-cycle PDSA approach, implementing strategies at scale without the iterative testing and incremental refinements necessary to validate effectiveness. This approach increases the risk of deploying unproven or inefficient interventions. • Gaps in Transitioning from Analysis to Action (Scoring Element 8.6): Six projects did not adequately assess the success of their strategies or identify concrete follow-up activities based on their data.

State Level
This resulted in a failure to capture lessons learned or establish a clear roadmap for the next phase of the improvement cycle. • Methodological Inconsistency and Lack of Quantitative Evidence (Scoring Elements 9.1 and 9.2): Several projects did not maintain consistent data collection methodologies between baseline and repeat measurements, introducing potential bias. Additionally, multiple initiatives lacked the quantitative data necessary to prove measurable improvements in care processes or outcomes, leaving the actual impact of these projects unverified. • Inconsistency in Attributing Gains to Interventions (Scoring Elements 9.3 and 9.4): A significant number of projects did not provide sufficient documentation or statistical evidence to link performance gains to the specific interventions implemented. Without isolating the effects of the selected strategy from external factors, such as seasonal trends or operational changes, the results remain anecdotal rather than scientifically attributed. • Absence of Sustained Improvement (Scoring Element 9.5): Among projects eligible for multi-year review, none successfully demonstrated sustained, year-over-year improvement through repeated measurements. This indicates a challenge in embedding and maintaining quality gains over the long term. • The projects' overall impact was constrained by a lack of demonstrable progress, as only 11 of 29 projects provided evidence to reach a "High Confidence" rating for significant improvement. This shortfall suggests that most projects either did not achieve the intended scale of results or failed to produce the rigorous documentation necessary to confirm that meaningful improvement occurred.
Recommendations
• Revise PIP aim statements to explicitly include the improvement strategies that will be used to achieve the stated goals (2.1). • Update PIP aim statements to clearly identify the population intended for the project. This should include defining characteristics such as eligibility criteria, demographics, or clinical conditions relevant to the PIP (2.2). • Ensure aim statements include a clear time period for the PIPs to be conducted (2.3). • Ensure aim statements are written in a clear and concise manner, focusing only on the essential elements (2.4). • Ensure that PIP aim statements are structured so they can be evaluated for success. This includes clearly stating the improvement goal, defining the target population, and outlining the improvement strategy. Aim statements should be specific enough to allow measurement of progress and determination of whether the desired outcome has been achieved (2.5). • Develop PIP aim statements that include measurable components, such as specific metrics or numeric targets, to allow for clear evaluation of progress and success. Incorporating quantifiable elements ensures that improvement efforts can be tracked over time and outcomes can be objectively assessed (2.6). • Ensure that future PIPs explicitly define the target populations in direct alignment with the PIP question to ensure that the scope of the study is clearly bounded and the resulting data is accurately representative (3.1). • Ensure that all selected variables are directly mapped to the PIP question, providing the comprehensive data coverage necessary to fully validate project outcomes (5.1).

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• Strengthen the use of longitudinal data tracking to ensure that performance metrics provide a clear historical comparison and serve as a primary evidence base for selecting and refining quality improvement activities (5.5). • Implement formal inter-rater reliability protocols, such as standardized training or periodic audit checks, to ensure that all individuals involved in data collection apply measurement criteria consistently (5.9). • Ensure that all future projects include a strictly defined baseline measurement period followed by consistent repeat measurements to provide a valid comparative analysis of project impact over time (7.2). • Integrate standardized statistical tests, such as p-value calculations or confidence intervals, into final evaluations to verify that any recorded improvements are statistically significant and represent genuine progress (7.3). • Design future analyses to include segmented data reporting, allowing for a side-by-side comparison of results across various subgroups or sites to better identify specific areas of success and opportunities for targeted improvement (7.6). • Utilize simplified data visualization tools and executive-style summaries to ensure that future findings are communicated clearly, focusing on essential metrics that are easily understood (7.7). • Build upon existing planning processes by formally documenting the evidence base, whether from peer-reviewed literature, internal pilots, or industry best practices, that supports the likelihood of the selected intervention achieving its targeted goals (8.1). • Consistently apply the PDSA framework by conducting smaller, rapid test cycles that allow for real-time adjustments and data-driven evidence of success prior to broader scaling (8.3). • Explicitly link data interpretations to future strategic decisions, ensuring that every project conclusion includes a clear assessment of success and a roadmap for subsequent follow-up or scaling (8.6). • Build upon existing data collection frameworks by establishing a methodology at the baseline stage that remains unchanged throughout all repeat measurement cycles (9.1). • Ensure that PIPs include quantitative evidence of improvement by collecting and analyzing data that demonstrates measurable change from baseline to remeasurement. This requires establishing clear metrics, setting numeric targets, and consistently tracking results throughout the project. Incorporating statistical analysis or trend comparisons can strengthen the validity of findings and confirm whether interventions produced meaningful improvements in processes or outcomes of care (9.2). • Ensure reports include an evaluation of improvements being the result of the interventions (9.3). • Integrate formal statistical analysis into final reporting to validate that any recorded improvements are mathematically significant. Utilizing tools such as t-tests or Chi-square analysis will provide the necessary objective proof that the interventions, rather than chance, drove the change in performance (9.4). • To increase the frequency of high-confidence outcomes, DHS and MCOs should build upon current momentum by refining data collection methods and success criteria, ensuring future results more consistently demonstrate the significant and verifiable improvements required for a high confidence rating.

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.

In accordance with 42 CFR § 438.360, states may substitute certain validation activities with results from private accreditation reviews, provided the standards are comparable to those outlined in federal protocols. Wisconsin DHS identifies Healthcare Effectiveness Data and Information Set® measures for validation, which are reviewed by a National Committee for Quality Assurance-certified auditor before submission to DHS. While MetaStar does not conduct the formal validation of these measures, it performs an analysis of the reported results to support quality oversight and improvement efforts. MetaStar evaluated the measures reported in CY 2025.

Table 5: PMV Summary of Findings and Recommendations – State Level

State Level
Strengths

• FCMH - C4K demonstrated strengths with the following measures:
  ○ IMA – Combo 2 achieved high compliance rates for the adolescent vaccine series, demonstrating effective preventative outreach.
  ○ LSC achieved high compliance which signified a robust POC testing culture. This reflects successful provider education and a highly effective reminder system that ensures children are screened for lead exposure by their second birthday.
• No strengths were identified for the BC+ or SSI; performance across all identified measures remained below the 75th percentile benchmark.

Weaknesses/Opportunities for Improvement

• BC+ demonstrated opportunities for improvement in the following measures:
  ○ CIS – Combo 3: Performance reflects a failure to complete the full 10-vaccine series by the second birthday, indicating a need for more aggressive 'catch-up' scheduling and parent education.
  ○ IMA – Combo 2: Rankings below the 50th percentile signify a drop-off in adolescent immunization rates (Meningococcal, Tdap, HPV), often due to lower frequency of office visits in this age demographic.
  ○ AMR – Total: Performance indicates an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations.
  ○ WCV – Total: Low percentile ranking suggests a decline in annual well-child engagement, potentially driven by fragmented care coordination or barriers to physical office visits.

State Level

- SSI demonstrated opportunities for improvement in the following measures:
  - AMR – Total: Performance indicates an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations.
  - SSD: Performance indicated a critical gap in metabolic monitoring for high-risk members on antipsychotic medications. This suggests a lack of coordination between behavioral health providers and primary care to ensure annual A1c or glucose testing.
  - FUH – 30 Days Total: Falling below the 50th percentile reflected an inability to successfully re-engage members in community-based care within 30 days of an inpatient psychiatric discharge. This gap points to a breakdown in discharge planning and inadequate post-discharge outreach.
- FCMH - C4K demonstrated opportunities for improvement in the following measures:
  - FUH – 7- and 30-Days Ages 6 – 17: Performance indicated a critical delay in connecting foster youth to community-based providers following a psychiatric hospitalization. Failing to meet the 7-day "gold standard" significantly increases the risk of readmission and placement disruption.
  - FUM – 7- and 30-Days Ages 6 – 17: Rankings below the 50th percentile for follow-up after an ED visit for mental illness suggested a lack of rapid-response outpatient appointments. This gap indicates that emergency care is often treated as an isolated event rather than a trigger for intensive care management.

Recommendations

- AMR - Total:
  - Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence.
  - Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management.
- CIS, IMA, and WCV:
  - Implement value-added member engagement programs or small incentives to encourage the completion of age-appropriate wellness visits and vaccinations.
  - Provide clinical teams with frequent "gap-to-goal" lists to prioritize scheduling for pediatric and adolescent members approaching key age milestones.
- FUH and FUM:
  - Expand the use of telehealth for post-discharge follow-up visits to mitigate common barriers such as transportation and scheduling conflicts.
  - Enhance notification systems for emergency department and inpatient discharges to ensure care managers can coordinate the required seven-day follow-up window.
- SSD:
  - Support behavioral health providers in performing or coordinating metabolic screenings (Glucose or A1c) during routine psychiatric visits.
  - Improve the bidirectional sharing of laboratory results between primary care and behavioral health providers to ensure comprehensive monitoring and reduce duplicate testing.

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:

- Managed Care Organization Standards
- Quality Assessment and Performance Improvement Standards
- Grievance Systems Standards

In accordance with 42 CFR § 438.360, states may use results from private accreditation reviews to avoid duplication, provided the standards are comparable to those outlined in EQR protocols and federal regulations. MetaStar conducted a crosswalk comparing requirements assessed in the Compliance with Standards review to those evaluated through the NCQA Health Plan Accreditation. This analysis identified gaps between the two sets of requirements. To address these gaps, MCOs submitted additional documentation, allowing for a comprehensive evaluation across the three general categories: MCO Standards, QAPI, and Grievance Systems.

These standards are reviewed on a two-year cycle. Year one focuses on MCO Standards, while year two addresses QAPI and Grievance Systems standards. This report reflects findings of year one, specifically the evaluation of MCO Standards, conducted in CY 2025.

Table 6: Compliance with Standards - Summary of Findings and Recommendations – State Level

State Level
Strengths
• The MCOs ensured timely access to care and services by requiring network providers to meet established standards based on the urgency of members' needs. Providers maintained hours of operation consistent with those offered to commercial and Medicaid FFS members, and appointment and facility wait times were monitored to prevent discrimination. MCOs made medically necessary services available 24/7. Mechanisms were in place to ensure provider compliance, including regular monitoring and prompt corrective actions when necessary. • The MCOs actively supported the State's efforts to deliver services in a culturally competent manner to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and disabilities. The organizations incorporated the National CLAS Standards into its practices and care management services, promoted these standards among providers, and increased network diversity to meet members' linguistic and cultural needs. Members were permitted to select or change providers based on cultural or linguistic preferences, and the MCOs

State Level
ensured that each member was linked to a primary care provider or clinic capable of delivering care with cultural sensitivity, understanding, and respect. • MCOs maintained comprehensive policies and procedures for service authorizations that complied with federal and contractual standards. The organizations ensured consistent application of review criteria and consulted with requesting providers when appropriate. Services were authorized in sufficient amount, duration, and scope to meet members' needs, and decisions were never based solely on diagnosis or condition. The MCOs provided timely written notices of decisions, including reasons and appeal rights, within required timeframes for both standard and expedited requests. Expedited decisions were made within 72 hours when necessary to protect member health, with extensions granted only under allowable circumstances. The MCOs also ensured coverage and payment for emergency and post-stabilization services regardless of provider network status, and did not deny payment for qualifying emergency conditions. • The MCOs consistently provided member information in a clear, accessible, and culturally appropriate manner. Written materials critical to obtaining services, including provider directories, member handbooks, and notices, were available in prevalent non-English languages and alternative formats at no cost, with conspicuous taglines explaining translation and interpretation options. MCOs ensured oral interpretation in any language and written translation in prevalent languages, as well as auxiliary aids such as TTY/TDY and ASL. Electronic materials met accessibility standards and were prominently posted online, with paper copies provided upon request within five business days. All written materials used plain language, appropriate font size, and formats accommodating members with disabilities or limited English proficiency. Members were notified of available interpretation and auxiliary aids, and the MCOs made good faith efforts to provide timely notice of provider terminations. Additionally, the MCOs distributed member handbooks within required timeframes and maintained an up-to-date online provider directory with comprehensive details, including provider accessibility and cultural competence information. • The MCOs ensured that members consistently received information on all available treatment options and alternatives in a manner appropriate to their condition and level of understanding. Members were given the opportunity to choose a primary care provider within the network, and designations were communicated promptly when applicable. MCOs maintained culturally appropriate care by supporting provider selection based on linguistic and cultural needs. Additionally, the MCOs did not restrict providers acting within their lawful scope of practice from advising or advocating on behalf of members regarding health status, treatment options, associated risks and benefits, and the member's right to participate in health care decisions, including the right to refuse treatment and express future preferences. • The MCOs maintained robust written policies and procedures for provider selection, credentialing, and recredentialing, ensuring compliance with all federal and state requirements. Initial credentialing included primary source verification of licensure, disciplinary status, and payment eligibility, while recredentialing occurred at least every three years with performance evaluations using QAPI data and member feedback. Peer review processes were in place, and the MCOs retained oversight of delegated credentialing decisions. The organizations ensured non-discrimination in provider selection, verified licensure and accreditation, prohibited contracting with excluded providers, and maintained mechanisms for suspension, termination, and appeals in accordance with federal law.

State Level
• The MCOs maintained comprehensive written policies for provider selection, credentialing, and recredentialing, ensuring compliance with federal and state standards. Initial credentialing included primary source verification of licensure, disciplinary status, and payment eligibility, while recredentialing occurred at least every three years with performance evaluations using QAPI data and member feedback. Peer review processes were implemented, oversight of delegated credentialing was retained, and mechanisms for suspension, termination, and appeals were maintained. The MCOs verified licensure and accreditation, ensured non-discrimination in provider selection, and prohibited contracting with excluded providers.
Weaknesses/Opportunities for Improvement
• Lack of Adequate Access to Services (Scoring Elements M1.3, M1.4 and M1.7): Several MCOs did not meet requirements to provide or arrange for members to obtain a second opinion from a network provider or arrange for members to receive one out of network at no cost, to cover services out of network for as long as the MCO's provider network is unable to provide them, or to make the provider directory available in paper form to members upon request at no cost. Gaps in these areas reflect incomplete assurances of access and support for members. • Delayed Access to Care (Scoring Element M2.4): Most MCOs did not meet requirements to ensure the provision of medically necessary high-risk prenatal care within two weeks of a member's request for an appointment, or within three weeks if the request is for a specific MCO provider who is accepting new members. Failure to specify timeframes in policies and procedures affects members' abilities to obtain timely medical care when needed. • Compliance Gaps in MCO Care Coordination (Scoring Elements M5.4, M6.2, and M6.5): Several MCOs did not meet key contract requirements related to sharing assessment information with other MCOs to prevent duplication of activities, developing care plans for members with special health care needs, and implementing member-level needs stratification. Gaps in these areas undermine continuity of care. • Systemic Issues in Adherence to Disenrollment Requirements (Scoring Elements M7.2, M7.3, M7.4, M7.5, and M7.6): Multiple MCOs' documentation failed to demonstrate compliance with requirements to ensure accurate, timely, and member-driven disenrollment actions specific to voluntary disenrollments, disenrollments during lock-in periods, handling exemption requests, system based disenrollments, and providing notification of member disenrollment from the service area or member death to DHS. These findings raise concerns related to the protection of member rights. • Deficiencies in Compliance with Emergency Services Requirements (Scoring Elements M8.8 and M8.9): MCOs failed to demonstrate compliance with member protections in emergency care situations related to payment liability and ensuring members were sufficiently stabilized for transfer or discharge to ensure safe, clinically guided transitions of care. • Limitation of Member Rights (Scoring Elements M11.3, M11.4, and M12.1): Several MCOs had not developed or implemented written restraint policies or had advance directives policies in place that met all contract requirements. In addition, documentation from three MCOs did not comply with applicable Federal and State laws for the protection of member rights. • Compliance Deficiencies Related to Practice Guidelines (M15.1, M15.2, and M15.3): Multiple MCOs did not provide adequate documentation to reflect practice guidelines were developed or adopted in accordance with requirements or ensure utilization management activities consistently aligned

State Level
with established practice guidelines. In addition. Most MCOs did not demonstrate practice guidelines were disseminated to all providers and made available to members or potential members upon request.
Recommendations
• Amend written guidance related to second opinions to ensure members are able to obtain a second opinion from an out-of-network provider at no cost (M1.3). • Revise documentation to include organizations will cover out-of-network services for members for as long as the organization's provider network is unable to provide them (M1.4). • Ensure documentation includes the requirement that members may receive a paper copy of the provider directory at no cost (M1.7). • Develop and implement policies and procedures to include members will receive high risk prenatal care within two weeks of the request for an appointment, or within three weeks if the request is for a specific MCO provider who is accepting new members (M2.4). • Revise documentation to ensure MCOs share with other MCOs serving a member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated (M5.4). • Update documentation to ensure MCOs produce a treatment or service plan for members with special health care needs determined through assessment to need a course of treatment or regular care monitoring, and follow required criteria for development and review (M6.2). • Ensure documentation that demonstrates organizations have an appropriate care management infrastructure to serve SSI members is developed and implemented within the required contract timeframe (M6.3). • Revise guidance to ensure MCOs incorporate individual member-level needs stratification as an input for developing individual care management plans, and use those plans to provide care management for members, periodically reassess whether the members are assigned to the appropriate strata, and continuously monitor and enhance the MCO's stratification method to improve the health outcomes for members (M6.5). • Update written guidance to include members may voluntarily disenroll from a MCO for any reason when the member is not in the lock-in period and that voluntary disenrollment requests must come from the member, the member's family, or legal guardian (M7.2). • Update written guidance to include all reasons that members may disenroll from the organizations when in the lock-in period (M7.3). • Revise disenrollment policies and procedures to include all system-based disenrollment reasons (M7.4). • Amend documents to specify that when the organizations have identified and verified a member has died or is no longer in the service area, the organizations must provide prompt written notification and proof of the change to DHS or the appropriate entity designated by DHS (M7.5). • Update written guidance to include the MCOs are to direct all members with exemption requests to the Enrollment Specialist, and include all required exemption request reasons (M7.6). • Revise guidance to include that members who have an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member (M8.8).

State Level
• Amend documentation to ensure MCOs in coordination with the attending emergency physician, or the provider actually treating the member, are responsible for determining when members are sufficiently stabilized for transfer or discharge (M8.9). • Develop and implement restraint policies (M11.3). • Revise policies and procedures regarding advance directives to include all requirements (M11.4). • Amend documents to include compliance with all applicable Federal and State laws for the protection of member rights (M12.1). • Update the process for developing and adopting best practice guidelines to include all requirements (M15.1). • Revise written guidance for how decisions for utilization management, member education, coverage of services and other areas to which the practice guidelines apply to ensure they are consistent with the guidelines (M15.2). • Ensure practice guidelines are disseminated to providers and available to members upon request (M15.3).

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 2025.

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

State Level
Strengths
• DHS provided detailed information about the data sources used for network adequacy calculations. The HPN and HFN datasets are submitted to the state with an attestation from the MCO on the data's accuracy. Member data is sourced from the state's MMIS which is reconciled with the network adequacy dashboard by age group. • DHS utilizes ESRI analysis software with SAS Explore and Visualization analytics to assess network adequacy indicators. SAS is the data vendor contracted by DHS to maintain enrollee and providers related data. Each MCO is assigned a BQO analyst who evaluates the network adequacy results and produces an annual report and scorecard. • The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval" have met network adequacy standards.

State Level
Weaknesses/Opportunities for Improvement
• DHS has identified challenges with accurately identifying provider types in some instances. • The QA process only looks at potential outlier results when identified by an analyst. • The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval with Conditions," "Denied," and "Decertified" have not met network adequacy standards. • The wait time to receive an appointment across all MCO provider networks was at or below the 15-business day standard in 34 out of 78 appointments, which results in 43.6 percent. Common barriers to receiving an appointment were the provider not accepting new members, the provider not accepting the MCO plan, or personal information being required to receive an appointment date.
Recommendations
• DHS is working towards improvements to the process in Phase II of the network adequacy dashboard project with SAS, DHS's data warehouse vendor. Among the improvements include enhanced provider type identification and trend analysis to improve QA of the results. • The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Improve provider networks to reduce the wait time to receive an appointment.

Protocol 9: Conducting Focus Studies of Health Care Quality - Care Management Review – Supplemental Security Income Program

Care Management Review is an optional activity designed to assess key aspects of care management practices and evaluate each MCO's compliance with its contract with DHS. This review supports the goals of the Supplemental Security Income program, which aims to improve member health outcomes, enhance quality of care, and reduce healthcare costs.

The SSI program achieves these goals through a comprehensive, integrated care model that addresses members' medical, behavioral health, and social needs. Each MCO is responsible for implementing a team-based care management approach that ensures coordination and integration across all aspects of a member's care. Additionally, MCOs must promote effective communication and shared decision-making between the care management team and the members. This report evaluated care management practices from CY 2024.

Table 8: SSI CMR - Summary of Findings and Recommendations – State Level

State Level
Strengths
• None identified.
Weaknesses/Opportunities for Improvement
• The organizations did not complete member screens within 60 days of enrollment or re-enrollment, and annually thereafter.

State Level
• The organizations did not complete care plans within the required timeframes, either 30 days after screening or 90 days post-enrollment, whichever came first. Documentation did not include all contract-required elements, such as member-centered goals, sequenced interventions, readiness to self-manage, and supports addressing physical, behavioral, and dental health, medications, ADLs/IADLs, and SDoH. Care plans were not shared with all required team members, and missing documented member agreement prior to implementation. When applicable, consent from legal representatives was not properly recorded. • The organizations did not include member engagement and care plan oversight in alignment with contract expectations. Members were not contacted at the required frequency based on their stratification level, with a minimum of one contact every 12 months. Timely follow-up was not provided for all identified member needs and requests, such as physical/behavioral health, referral/resource coordination, advance care planning, social/community, SDoH, and program benefit assistance. • The organizations did not ensure care plans were reviewed at least annually and updated as needed to reflect changing member needs. Care plan updates prompted by significant medical or behavioral health changes, frequent transitions between care settings, or identification of care gaps by the care management team, were not completed. Following any critical event, the members' stratification level was not reassessed to ensure appropriate care coordination. • The organizations did not ensure timely member follow-up after inpatient hospital discharge, which is to occur within five business days. Follow-up did not include medication reconciliation, assessment of the member's ability to manage medications, or support in understanding their treatment plan, medication schedule, and condition management. • The organizations' WICT Core Team did not meet weekly to discuss member needs. Monthly face-to-face meetings with members were not completed to ensure supportive collaborative care planning and strong provider-member relationships.
Recommendations
• Complete member screens within 60 days of enrollment or re-enrollment, and annual thereafter. • Complete care plans within required timeframes, either 30 days after screening or 90 days post-enrollment, whichever comes first. Document all contract-required elements, including member-centered goals, sequenced interventions, readiness to self-manage, and supports addressing physical, behavioral, and dental health, medications, ADLs/IADLs, and SDoH. Share plans with all required team members and document member agreement prior to implementation. Record consent from legal representatives, when applicable. • Maintain member engagement and care plan oversight in alignment with contract expectations. Contact members at the required frequency based on their stratification level, with a minimum of one contact every 12 months. For all members' needs and requests, ensure timely follow-up. • Ensure care plans are reviewed at least annually and updated as needed to reflect changing member needs. Update care plans when prompted by significant medical or behavioral health changes, frequent transitions between care settings, or identification of care gaps by the care management team. Reassess the members' stratification level following any critical event. • Contact members for follow-up after inpatient hospital discharge, within five business days. Ensure all post hospitalization follow-up includes medication reconciliation, assessment of the member's

State Level
ability to manage medications, and support in understanding their treatment plan, medication schedule, and condition management. • Ensure the WICT Core Team meets weekly to discuss member needs and completes monthly face-to-face meetings with members to establish supportive collaborative care planning and strong provider-member relationships.

Protocol 9: Conducting Focus Studies of Health Care Quality - Care Management Review – Foster Care Medical Home

Care Management Review is an optional activity that evaluates key components of care management practices and assesses PIHP compliance with its contract with DHS. The Foster Care Medical Home program was established in 2014 through an Alternative Benefit Plan State Plan Amendment, authorized under Section 1937 of the Social Security Act. Operated by a single MCO in six southeastern Wisconsin counties, the program is a prepaid inpatient health plan designed to provide comprehensive, coordinated care for children in out-of-home care. Participation in the program is voluntary and available to all children placed in eligible out-of-home care settings under the jurisdiction of the child welfare system within the designated counties.

To meet program requirements, the PIHP must implement a health care management structure that ensures coordination and integration of all aspects of a child's health care. This includes fostering effective communication among all individuals involved in the child's care to support continuity, responsiveness, and shared decision-making. This report evaluated care management practices from CY 2024.

Table 9: FCMH CMR - Summary of Findings and Recommendations – State Level

State Level
Strengths
• The PIHP demonstrated strong performance in ensuring the OHC Health Screens were comprehensive, reflecting thorough assessments of health conditions that require prompt medical attention, an unclothed, symptom targeted physical examination, including injury surveillance, and identification of medical treatment and follow up. These practices support early identification of concerns and promote continuity of care for members entering out-of-home placements. • The PIHP demonstrated strong practices in care planning and review. Initial care plans were consistently developed within 60 days of enrollment, meeting timeliness standards. Ongoing reviews occurred at least every six months or sooner when indicated. The care plans were comprehensive, addressing the full scope of member needs and supporting coordinated, person-centered care. • The PIHP demonstrated strong practices in transition planning. Initial transition plans were created in a timely manner, and ongoing reviews occurred at least every six months, ensuring plans

State Level
remained relevant to members' evolving needs. Transition plans were comprehensive, supporting continuity of care and successful transitions across settings.
Weaknesses/Opportunities for Improvement
• The OHC Health Screen was completed more than two business days from out-of-home placement in over half the records reviewed (1.1). • The initial health assessment was completed more than 30 days of enrollment in some records (2.1). • An assessment of members' oral health needs was the main reason initial health assessments were not comprehensive (2.2). • Records lacked a care plan review and update within 30 days of discharge from an inpatient mental health hospitalization (3.3). • Records commonly lacked input from the parent/legal guardian, child welfare case worker, OHC care provider, and the member, as appropriate, during the care plan timeframe (3.4). • The actual rate for Care Plan Input exceeded DHS improvement targets for three consecutive years, indicating positive progress. However, the current rate of 42.9 percent remains well below the long-term goal of 90 percent, meaning significant gaps persist. Missing input from key individuals continues to be a common barrier, driven by factors such as placement instability, limited caregiver availability, and cross-system coordination challenges. Therefore, even with improvement trends, targeted strategies are needed to ensure care plans consistently reflect member and caregiver perspectives and move closer to full compliance. • Monitoring and follow-up of members' needs and services was not timely for ongoing dental or physical health needs (4.1). • Input from the parent/legal guardian, child welfare case worker, OHC care provider, and the member was lacking during the transition plan timeframe (5.3).
Recommendations
• Develop a process and tracking mechanism to ensure OHC Health Screens are conducted timely (1.1). • Develop a process and tracking mechanism to ensure initial health assessments are completed timely (2.1). • Create procedures to ensure initial health assessments are comprehensive, including an evaluation of oral health needs (2.2). • Prioritize reviewing and updating care plans within 30 days of hospitalization discharge (3.3). • Develop a process to obtain input from all required individuals into each care plan review (3.4). • Create a procedure and tracking mechanism to ensure member needs and services receive appropriate follow-up every four to six weeks (4.1). • Develop a process to obtain input from all required individuals into each transition plan review (5.3).

Appendix A: Information Systems Capabilities Assessment

Assessment of a MCO's information system is a component of several mandatory review activities, including Performance Measure Validation. This assessment ensures that MCOs have the capacity to accurately collect, analyze, and report data, as required by their contract with

DHS. Each MCO must maintain a health information system capable of supporting these functions.

Under 42 CFR § 438.360, states may use results from private accreditation reviews in place of certain EQR activities, provided the standards are comparable to those outlined in 42 CFR § 438.358 and the CMS EQR protocols. MetaStar conducted a crosswalk comparing the requirements of the Information System Capabilities Assessment with those evaluated through the NCQA Health Plan Accreditation. This analysis confirmed that the accreditation review fully addresses all requirements outlined in Appendix A of the CMS EQR Protocol.

For MCOs accredited by NCQA and audited by an NCQA-certified HEDIS® Licensed Organization, the organization's ability to report HEDIS® measures is considered sufficient to meet the information system assessment requirements. For MCOs not evaluated by an NCQA-certified HEDIS® auditor, MetaStar conducts a full review of the organization's information system capabilities. This report evaluated the findings from the audits conducted in CY 2025.

Table 10: ISCA - Summary of Findings and Recommendations – State Level

State Level
Strengths
• All organizations maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness. • Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Optional Reviews: Other Medicaid Programs

Record Review – Children with Medical Complexity

Children with Medical Complexity represent a population covered under Wisconsin Medicaid's targeted case management benefit. This benefit is administered on a fee-for-service basis and is available to all Medicaid-enrolled members who meet medical necessity criteria for covered services. It operates independently from managed care organizations and prepaid inpatient health plans.

At the direction of DHS, this review activity assesses the access, quality, and appropriateness of care provided to children with medical complexity. The findings help inform program oversight and identify opportunities to strengthen care coordination and service delivery for this vulnerable population. This review was not conducted in CY 2025 to allow time for revisions to the review measures. The activity will resume in CY 2026. As a result, no findings from this review are included in this report.

Record Review – HIV/AIDS Health Home

The HIV/AIDS Health Home program is an optional Medicaid benefit established under Section 2703 of the Affordable Care Act and Section 1945 of the Social Security Act. It allows states to create health homes that coordinate care for individuals with chronic conditions across medical and community-based settings. The program's goals are to improve health outcomes, reduce preventable hospitalizations and emergency room visits, and lower overall Medicaid costs.

Participation in the program is voluntary. Eligible members must have a diagnosis of human immunodeficiency virus and at least one additional chronic condition, or be at risk of developing another chronic condition. Health home providers are accountable for the member's total care, using a member-centered model that includes a multidisciplinary care team. This team works collaboratively with the member to address medical, dental, behavioral health, pharmacy, care management, and social service needs.

The HIV/AIDS Health Home Record Review is conducted every three years to evaluate the quality, coordination, and appropriateness of care provided. The most recent review was completed in CY 2023 and planned again for CY 2026; therefore, no findings are included in this report.

Record Review – Obstetrics Medical Home/Healthy Birth Outcomes

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

During CY 2025, DHS directed MetaStar to perform data abstraction reviews of its Medical Home initiative for pregnant women. Results from the data abstraction are used by DHS to determine administrative payments to organizations, based on compliance with specific requirements detailed in the DHS contract. Due to the timelines associated with this retrospective review, the results of this optional activity are reported separately.

Overview of Managed Care Organizations and Enrollment

As of December 2025, enrollment was as follows:

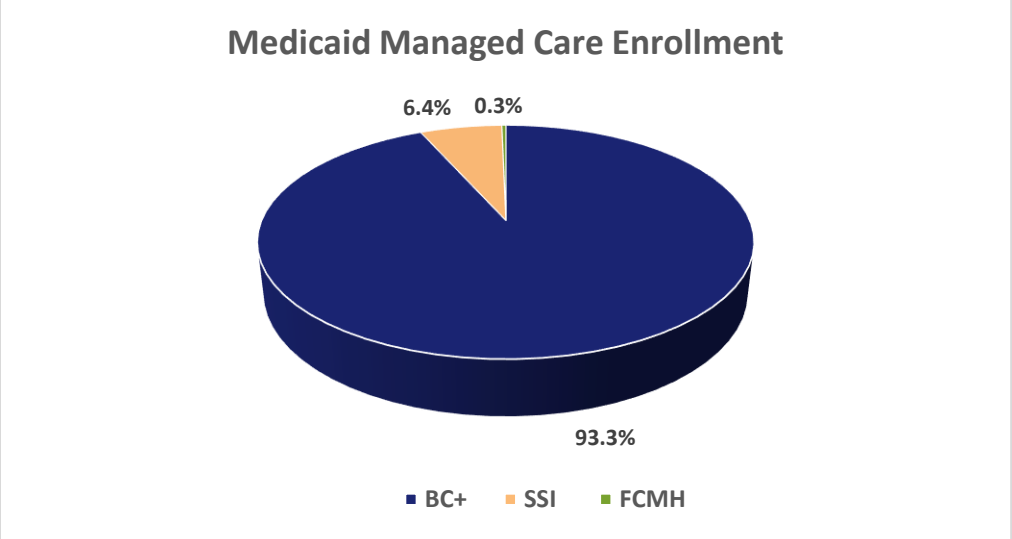
Table 11. State Level Enrollment

Program	Enrollment
BC+	762,758
SSI	52,020
FCMH	2,633
CCF	0
WM	0

Current enrollment data is available at the following DHS website:

Wisconsin Medicaid Managed Care - Monthly HMO Enrollment Reports (County, HMO, and Special Programs Summaries)

Chart 1: Medicaid Managed Care Enrollment



Children Come First and Wraparound Milwaukee programs concluded their operations in 2024. This transition marked the sunsetting of the original MCO-based care coordination model as Milwaukee County moved toward a more integrated, modernized system of care. While these specific programs are no longer active, the mission of providing youth-centered, strength-based mental health support continues through a new landscape of community-based services. Families who previously relied on these programs have been transitioned to broader initiatives,

such as Comprehensive Community Services and REACH, ensuring that the legacy of individualized care remains accessible under a more streamlined county framework.

The table below outlines the programs operated by each organization, along with the enrollment and accreditation status, where applicable.

Table 12. MCOs, Programs, Enrollment, and Accreditation Status as of December 2025

Managed Care Organization	Program(s) and Enrollment	Accreditation Organization and Status
Anthem Blue Cross and Blue Shield Health Plan	BC+: 115,027 SSI: 7,754	NCQA Medicaid Accreditation, with evaluation of the additional Medicaid Module Survey Expires: 10/18/2027
Children Come First	This program served children with mental health needs. Program ended services in 2024	Not Accredited
Chorus Community Health Plan, Inc.	BC+: 105,689 FCMH (C4K): 2,627	NCQA Medicaid Accreditation Expires: 12/26/2026
Dean Health Plan, Inc.	BC+: 34,654	NCQA Medicaid Accreditation Expires: 3/4/2028
Group Health Cooperative of Eau Claire	BC+: 40,564 SSI: 2,837	NCQA Medicaid Accreditation Expires: 9/5/2026
Group Health Cooperative of South-Central Wisconsin	BC+:6,381	NCQA Medicaid Accreditation Expires: 11/21/2026
Independent Care Health Plan	BC+: 28,284 SSI: 8,444	NCQA Medicaid Accreditation Expires: 11/29/2026
MercyCare Health Plan	BC+: 10,486	NCQA Medicaid Accreditation Expires: 12/18/2026
MHS Health Wisconsin	BC+: 42,991 SSI: 5,466	NCQA Medicaid Accreditation Expires: 8/12/2025
Molina Healthcare of Wisconsin	BC+: 63,100 SSI: 4,786	NCQA Medicaid Accreditation Expires: 6/20/2026

Managed Care Organization	Program(s) and Enrollment	Accreditation Organization and Status
Network Health Plan	BC+: 40,023 SSI: 3,811	NCQA Medicaid Accreditation Expires: 9/6/2026
Quartz Health Solutions, Inc.	BC+: 36,455 SSI: 631	NCQA Medicaid Accreditation Expires: 11/7/2026
Security Health Plan of Wisconsin, Inc.	BC+: 55,038 SSI: 784	NCQA Medicaid Accreditation Expires: 5/12/2026
UnitedHealthcare Community Plan	BC+: 184,066 SSI: 17,507	NCQA Medicaid Accreditation Expires: 2/8/2026
Prepaid Inpatient Health Plan	**Program(s)**	**Accreditation Organization and Status**
Wraparound Milwaukee	This program served children with mental health needs. Program ended services in 2024	Not Accredited

The following charts display enrollment by program for each MCO under BC+ and SSI. The Foster Care Medical Home is operated by a single MCO and is therefore not included as a graphic. Additionally, CCF and WM ended services in 2025 and have no enrollment data to report.

Chart 2. BadgerCare Plus

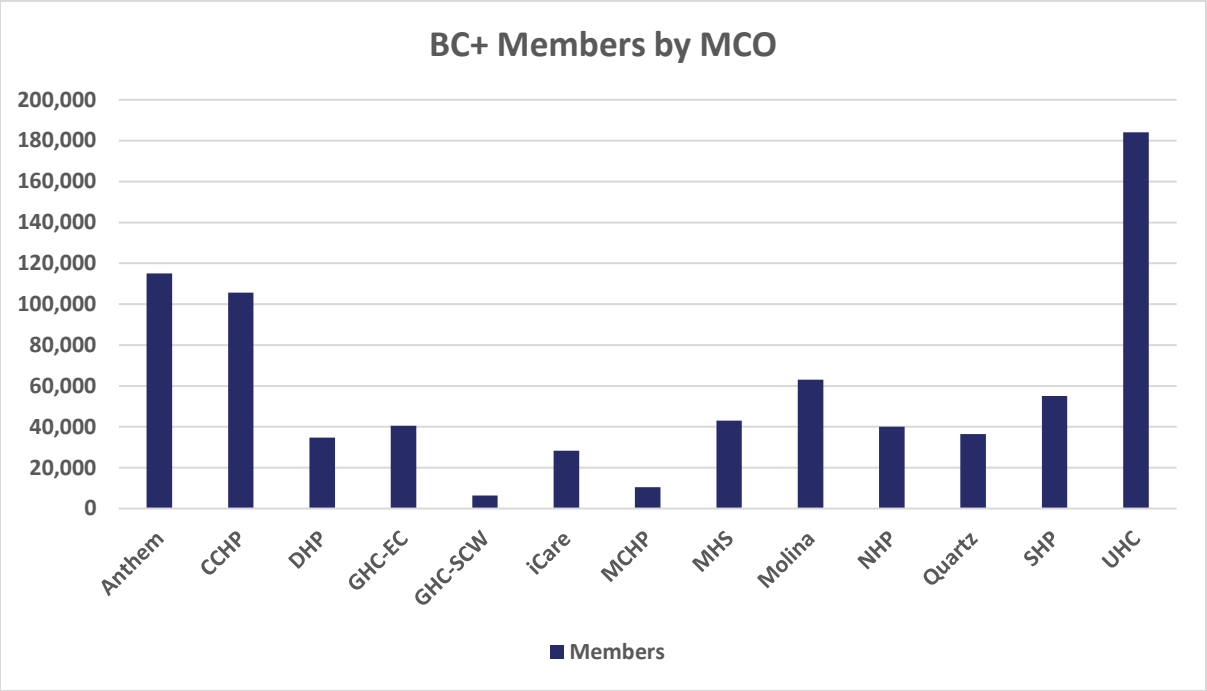
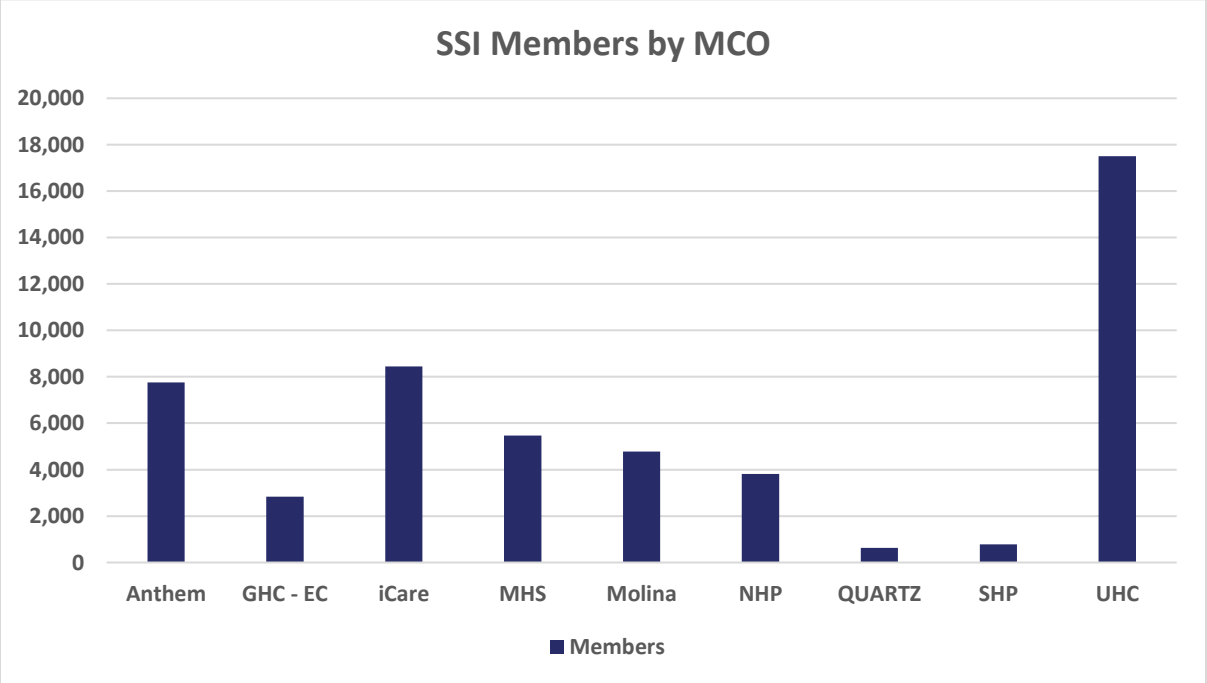


Chart 3. Supplemental Security Income



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 each MCO and PIHP participating in Medicaid Managed Care programs to conduct one clinical and one non-clinical PIP annually, which are based on DHS priority areas. While the MCOs may propose alternate topics, approval is at the discretion of DHS.

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 CY 2025. 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 using 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 methodology for determining whether an improvement is statistically significant depends on whether the measure is a HEDIS® measure. For HEDIS® measures, the HEDIS® Bias Determination methodology is applied to assess significance. Using HEDIS® Bias Determinations to assess rate changes ensures that observed differences are statistically significant and not due to random variation. This method provides a consistent, standardized approach aligned with NCQA guidelines.

When a rate change falls within the established threshold for a given measure, it is considered not statistically significant. This suggests that the observed change is likely attributable to normal variation or chance, rather than a true shift in performance. Conversely, when a rate change falls outside the threshold, it is deemed statistically significant, indicating a high likelihood that the change reflects a real difference in performance. If the significant change represents an improvement, the methodology supports a high level of confidence in the statistical validity of that improvement. Because these determinations are based on final rates, the underlying data is considered valid and reliable, further reinforcing the credibility of the findings.

For projects that did not utilize a HEDIS® measure, the significant improvement rating was determined by MetaStar through 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 organizations to 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 13. CY 2025 PIP Validation Results

MCO/PIHP	Topic	Clinical/Non-Clinical	Population	Methodology Rating	Significant Improvement Rating
Anthem	Diabetic Care	Clinical	Adults	Moderate Confidence	No Confidence
Anthem	Screening	Non-Clinical	Adults	No Confidence	No Confidence
CCHP – C4K	Emergency Department Utilization	Clinical	Children	High Confidence	No Confidence
CCHP – C4K	Birth to 3 Referral	Non-Clinical	Children	High Confidence	High Confidence
CCHP – BC+	Childhood Immunization Status	Clinical	Children	High Confidence	High Confidence
CCHP – BC+	Diabetic Care	Non-Clinical	Adults	Moderate Confidence	No Confidence
DHP	Prenatal and Postpartum Care	Clinical	Adults	High Confidence	No Confidence
DHP	Health Needs Assessment	Non-Clinical	Adults	High Confidence	High Confidence
GHC-EC	Follow-Up After Hospitalization for Mental Illness	Clinical	Adults	High Confidence	No Confidence
GHC-EC	Member Satisfaction	Non-Clinical	Adults	Moderate Confidence	Low Confidence
GHC-SCW	Colorectal Cancer	Clinical	Adults	High Confidence	No Confidence

MCO/PIHP	Topic	Clinical/Non-Clinical	Population	Methodology Rating	Significant Improvement Rating
GHC-SCW	Electronic Patient Portal	Non-Clinical	Adults	High Confidence	No Confidence
*i*Care	Comprehensive Diabetes Care	Clinical	Adults	Moderate Confidence	High Confidence
*i*Care	AODA Services in Pregnancy	Non-Clinical	Adults	High Confidence	No Confidence
MCHP	Childhood Immunization Status	Clinical	Children	Moderate Confidence	High Confidence
MCHP	Social Needs	Non-Clinical	Adults	Moderate Confidence	Moderate Confidence
MHS	Behavioral Health Disparities	Clinical	Adults	High Confidence	No Confidence
MHS	Health Needs Assessment	Non-Clinical	Adults	High Confidence	High Confidence
MHWI	Cervical Cancer	Clinical	Adults	High Confidence	No Confidence
MHWI	Member Satisfaction	Non-Clinical	Adults	Moderate Confidence	Moderate Confidence
NHP	Prenatal and Postpartum Care	Clinical	Adults	High Confidence	No Confidence
NHP	Social Determinants of Health	Non-Clinical	Adults	High Confidence	High Confidence
Quartz	Comprehensive Diabetes Care	Clinical	Adults	High Confidence	High Confidence
Quartz	Health Risk Assessment	Non-Clinical	Adults	Low Confidence	No Confidence
SHP	Comprehensive Diabetes Care	Clinical	Adults	High Confidence	High Confidence
SHP	Care Management Engagement	Non-Clinical	Adults	Moderate Confidence	High Confidence

MCO/PIHP	Topic	Clinical/Non-Clinical	Population	Methodology Rating	Significant Improvement Rating
UHC	Prenatal and Postpartum Care	Clinical	Adults	High Confidence	High Confidence
UHC	Food Insecurity Screening	Non-Clinical	Adults	Low Confidence	No Confidence
WM	Program Transition	Non-Clinical	Children	No Confidence	No Confidence

The table below 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. The state-level results are an aggregate of all clinical projects.

Table 14. Clinical PIP Methodology Rating

Standards	Scoring Elements	Percentage	Methodology Rating
Standard 1: PIP Topic	60/60	100.0%	High Confidence
Standard 2: PIP Aim Statement	72/84	85.7%	Moderate Confidence
Standard 3: PIP Population	27/28	96.4%	High Confidence
Standard 4: Sampling Method*	N/A	N/A	N/A
Standard 5: PIP Variables and Performance Measures	90/91	98.9%	High Confidence
Standard 6: Data Collection Procedures	150/152	98.7%	High Confidence
Standard 7: Data Analysis and Interpretation of PIP Results	102/106	96.2%	High Confidence
Standard 8: Improvement Strategies	76/84	90.5%	High Confidence
Standard 9: Significant and Sustained Improvement	29/47	61.7%	No Confidence
Methodology Rating	**606/652**	**92.8%**	**High Confidence**

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

The table on the next page 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 moderate. The state-level results are an aggregate of all non-clinical projects.

Table 15. Non-Clinical PIP Methodology Rating

Standards	Scoring Elements	Percentage	Methodology Rating
Standard 1: PIP Topic	48/49	98.0%	High Confidence
Standard 2: PIP Aim Statement	64/90	71.1%	Low Confidence
Standard 3: PIP Population	26/29	89.7%	Moderate Confidence
Standard 4: Sampling Method	5/5	100.0%	High Confidence
Standard 5: PIP Variables and Performance Measures	61/75	81.3%	Moderate Confidence
Standard 6: Data Collection Procedures	105/110	95.5%	High Confidence
Standard 7: Data Analysis and Interpretation of PIP Results	96/113	85.0%	Moderate Confidence
Standard 8: Improvement Strategies	72/90	80.0%	Moderate Confidence
Standard 9: Significant and Sustained Improvement	40/52	76.9%	Low Confidence
Methodology Rating	**517/613**	**84.3%**	**Moderate Confidence**

Performance Improvement Project - State Level Findings

The following table identifies strengths, weaknesses/opportunities for improvement, and recommendations for clinical PIPs validated in CY 2025. Strengths were 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 16. Clinical PIP: Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Assessment of Clinical PIP Methodology
Standard 1: PIP Topic
Strengths: The MCOs conducted and reported detailed research regarding the topic selection and importance to members.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 2: PIP Aim Statement
Strengths: None identified.

Assessment of Clinical PIP Methodology
Weaknesses/Opportunities for Improvement: Scoring element **2.1** evaluated that the aim statement clearly specified the improvement strategies. The aim statements in two projects lacked sufficient detail to describe how the intended improvements would be achieved. ***The scoring element was not met***. Scoring element **2.2** evaluated that the aim statements clearly specified the population of the PIPs. The aim statements in two projects lacked a precise description of the target population. ***The scoring element was not met***. Scoring element **2.4** evaluated that the aim statements were concise. The aim statements in two projects were overly detailed and included extraneous information beyond the core purpose of the PIP aim. ***The scoring element was not met***. Scoring element **2.5** evaluated that the aim statement was answerable. Three projects did not include an answerable aim statement. For two of these projects, the aim statements lacked critical components such as a defined improvement strategy or a clearly identified population, making it impossible to determine how the aim would be achieved or measured. The third project's aim statement was too vague and did not provide sufficient specificity to allow for evaluation of success. ***The scoring element was not met***. Scoring element **2.6** evaluated that the aim statements were measurable. Three projects did not include measurable aim statements. The aim statements lacked quantifiable components, such as specific metrics or numeric targets, making it impossible to determine progress or evaluate success. Without measurable aims, the projects cannot effectively track improvement or demonstrate achievement of the stated goals. ***The scoring element was not met***.
Recommendations: Revise PIP aim statements to explicitly include the improvement strategies that will be used to achieve the stated goals **(2.1)**. Update PIP aim statements to clearly identify the population intended for the project. This should include defining characteristics such as eligibility criteria, demographics, or clinical conditions relevant to the PIP **(2.2)**. Ensure aim statements are written in a clear and concise manner, focusing only on the essential elements **(2.4)**. Ensure that PIP aim statements are structured so they can be evaluated for success. This includes clearly stating the improvement goal, defining the target population, and outlining the improvement strategy. Aim statements should be specific enough to allow measurement of progress and determination of whether the desired outcome has been achieved **(2.5)**. Develop PIP aim statements that include measurable components, such as specific metrics or numeric targets, to allow for clear evaluation of progress and success. Incorporating quantifiable elements ensures that improvement efforts can be tracked over time and outcomes can be objectively assessed **(2.6)**.
Standard 3: PIP Population
Strengths: The MCOs clearly identified the PIP populations in relation to the aim statements.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 4: Sampling Method

Assessment of Clinical PIP Methodology
Strengths: Sampling was not utilized for any clinical PIPs. This section is not applicable.
Weaknesses/Opportunities for Improvement: Sampling was not utilized for any clinical PIPs. This section is not applicable.
Recommendations: Sampling was not utilized for any clinical PIPs. This section is not applicable.
Standard 5: PIP Variables and Performance Measures
Strengths: The MCOs selected PIP variables and performance measures that were clear indicators of performance.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 6: Data Collection Procedures
Strengths: The MCOs used valid and reliable procedures to collect PIP data and inform measurements.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 7: Data Analysis and Interpretation of PIP Results
Strengths: The MCOs used appropriate techniques to analyze PIP data and interpret results.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 8: Improvement Strategies
Strengths: The MCOs selected and implemented appropriate, evidence-based interventions that were likely to lead to desired improvements. See Appendix 2 for additional details on PIP interventions, including the effectiveness of each intervention used.
Weaknesses/Opportunities for Improvement: Scoring element **8.3** required the use of a rapid-cycle PDSA approach be used to test the selected improvement strategy. Three projects did not document the approach in the final reports, resulting in improvement strategies that were implemented without the iterative testing and incremental refinements necessary to validate effectiveness on a small scale before full implementation. ***The scoring element was not met***.
Recommendations: Consistently apply the PDSA framework by conducting smaller, rapid test cycles that allow for real-time adjustments and data-driven evidence of success prior to broader scaling **(8.3)**.
Standard 9: Significant and Sustained Improvement
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Scoring element **9.2** assessed if there was quantitative evidence of improvement in processes or outcomes of care. Seven projects did not demonstrate quantitative evidence of improvement in processes or outcomes of care. While activities were

Assessment of Clinical PIP Methodology
implemented, the projects lacked data showing measurable change from baseline to remeasurement. ***The scoring element was not met***. Scoring element **9.3** evaluated if improvement in performance was likely to be a result of the selected intervention. Two projects lacked this documentation. ***The scoring element was not met***. Scoring element **9.4** evaluated that there was statistical evidence to support that any observed improvement was the result of the interventions. There was insufficient evidence to satisfy the requirement for attribution for two projects. Without isolating the effects of the selected interventions, the reported improvements remain anecdotal and could potentially be attributed to seasonal trends or unrelated operational changes. ***The scoring element was not met***. Scoring element **9.5** evaluated if sustained improvement was demonstrated through repeated measurements over time. No clinical projects conducted demonstrated year-over-year improvements that have been sustained. This element only applies to PIPs conducted over two or more years. ***The scoring element was not met***.
Recommendations: Ensure that PIPs include quantitative evidence of improvement by collecting and analyzing data that demonstrates measurable change from baseline to remeasurement. This requires establishing clear metrics, setting numeric targets, and consistently tracking results throughout the project. Incorporating statistical analysis or trend comparisons can strengthen the validity of findings and confirm whether interventions produced meaningful improvements in processes or outcomes of care **(9.2)**. Ensure reports include an evaluation of improvements being the result of the interventions **(9.3)**. Integrate formal statistical analysis into final reporting to validate that any recorded improvements are mathematically significant. Utilizing tools such as t-tests or Chi-square analysis will provide the necessary objective proof that the interventions, rather than chance, drove the change in performance **(9.4)**.

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

Table 17. Clinical PIP Significant Improvement: Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Assessment of Clinical PIP Significant Improvement
Significant Improvement
Strengths: None identified.
Weaknesses/Opportunities for Improvement: The clinical projects' overall impact was constrained by a lack of demonstrable progress, as only six of 14 projects provided evidence to reach a "High Confidence" rating for significant improvement. This shortfall suggests that most projects either did not achieve the intended scale of results or failed to produce the rigorous documentation necessary to confirm that meaningful improvement occurred.
Recommendations: To increase the frequency of high-confidence outcomes, DHS and MCOs should build upon current momentum by refining data collection methods and success criteria, ensuring

Assessment of Clinical PIP Significant Improvement
future results more consistently demonstrate the significant and verifiable improvements required for a high confidence rating.

The table on the next page identifies strengths, weaknesses/opportunities for improvement and recommendations for non-clinical PIPs validated in CY 2025. Strengths were 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 18. Non-Clinical PIP: Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Assessment of Non-Clinical PIP Methodology
Standard 1: PIP Topic
Strengths: The MCOs conducted and reported detailed research regarding the topic selection and importance to members.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 2: PIP Aim Statement
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Scoring element **2.1** evaluated that the aim statements clearly specified the improvement strategies. The aim statements in three projects lacked sufficient detail to describe how the intended improvements would be achieved. ***The scoring element was not met***. Scoring element **2.2** evaluated that the aim statement clearly specified the population of the PIP. The aim statements in four projects lacked a precise description of the target population. ***The scoring element was not met***. Scoring element **2.3** evaluated that the aim statements clearly specified the time period for the PIPs. The aim statements in four projects did not include a time period for the PIPs. ***The scoring element was not met***. Scoring element **2.4** evaluated that the aim statements were concise. The aim statements in four projects were overly detailed and included extraneous information beyond the core purpose of the PIP aim. ***The scoring element was not met***. Scoring element **2.5** evaluated that the aim statements were answerable. Nine projects did not include an answerable aim statement. ***The scoring element was not met***. Scoring element **2.6** evaluated that the aim statements were measurable. Two projects did not include measurable aim statements. The aim statements lacked quantifiable components, such as specific

Assessment of Non-Clinical PIP Methodology
metrics or numeric targets, making it impossible to determine progress or evaluate success. Without measurable aims, the projects cannot effectively track improvement or demonstrate achievement of the stated goals. ***The scoring element was not met.***
Recommendations: Revise PIP aim statements to explicitly include the improvement strategies that will be used to achieve the stated goals **(2.1)**. Update PIP aim statements to clearly identify the population intended for the project. This should include defining characteristics such as eligibility criteria, demographics, or clinical conditions relevant to the PIP **(2.2)**. Ensure aim statements include a clear time period for the PIPs to be conducted **(2.3)**. Ensure aim statements are written in a clear and concise manner, focusing only on the essential elements **(2.4)**. Ensure that PIP aim statements are structured so they can be evaluated for success. This includes clearly stating the improvement goal, defining the target population, and outlining the improvement strategy. Aim statements should be specific enough to allow measurement of progress and determination of whether the desired outcome has been achieved **(2.5)**. Develop PIP aim statements that include measurable components, such as specific metrics or numeric targets, to allow for clear evaluation of progress and success. Incorporating quantifiable elements ensures that improvement efforts can be tracked over time and outcomes can be objectively assessed **(2.6)**.
Standard 3: PIP Population
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Scoring element **3.1** evaluated if the project populations were clearly defined in terms of the identified PIP question. Two projects did not fully meet the requirement to define project populations in alignment with the specific PIP question. This lack of clear parameters made it difficult to determine exactly which groups or data sets were included in the study, resulting in a misalignment between the stated improvement goals and the population being measured. ***The scoring element was not met.***
Recommendations: Ensure that future PIPs explicitly define the target populations in direct alignment with the PIP question to ensure that the scope of the study is clearly bounded and the resulting data is accurately representative **(3.1)**.
Standard 4: Sampling Method
Strengths: The MCOs utilized appropriate sampling methods.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Standard 5: PIP Variables and Performance Measures
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Scoring element **5.1** evaluated that the variables were adequate to answer the PIP question. Eight PIPs did not identify a complete set of variables necessary to fully address the stated PIP question. By omitting key metrics or failing to align variables with the

Assessment of Non-Clinical PIP Methodology
project's goals, these projects were unable to capture the data depth required to provide a comprehensive answer to the core improvement questions. ***The scoring element was not met***. Scoring element **5.5** assessed that performance measures monitored, tracked, and compared performance over time. Two projects did not fully meet the requirement to use performance measures for consistent longitudinal tracking, resulting in a limited ability to compare progress over time or use data-driven insights to inform the selection and evaluation of specific quality improvement activities. ***The scoring element was not met***. Scoring element **5.9** evaluated if the measures included a strategy to ensure inter-rater reliability (if applicable). Half of the applicable projects, three of six, did not include a formalized strategy to ensure inter-rater reliability, creating a risk that data collection remained subjective and lacked the necessary consistency between different evaluators to ensure valid results. ***The scoring element was not met***.
Recommendations: Ensure that all selected variables are directly mapped to the PIP question, providing the comprehensive data coverage necessary to fully validate project outcomes **(5.1)**. Strengthen the use of longitudinal data tracking to ensure that performance metrics provide a clear historical comparison and serve as a primary evidence base for selecting and refining quality improvement activities **(5.5)**. Implement formal inter-rater reliability protocols, such as standardized training or periodic audit checks, to ensure that all individuals involved in data collection apply measurement criteria consistently **(5.9)**.
Standard 6: Data Collection Procedures
Strengths: The MCOs used valid and reliable procedures to collect PIP data and inform measurements.
Weaknesses/Opportunities for Improvement: Scoring element **6.13** evaluated if member, clinical, service, or quality metrics were validated for accuracy and completeness as well as comparability across systems, when EHR data is used. The documentation for four projects failed to demonstrate that EHR data underwent a formal validation process. Specifically, there was no evidence that member, clinical, service, or quality metrics were assessed for accuracy, completeness, or comparability across different systems. Without this validation, the reliability of the performance measures and the resulting improvement trends cannot be confirmed. ***The scoring element was not met***.
Recommendations: Implement a standardized data validation protocol that requires explicit documentation of the methods used to verify EHR accuracy and completeness. This process must include a formal "cross-system audit" to ensure that data definitions remain consistent across different platforms. Furthermore, projects should provide evidence of periodic sample testing to confirm that the metrics reported in the PIP align perfectly with the source records in the clinical system **(6.13)**.
Standard 7: Data Analysis and Interpretation of PIP Results
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Scoring element **7.2** evaluated if the analysis included baseline and repeat measurements of project outcomes. Two projects did not fully adhere to the requirement for both baseline and repeat measurements, which limited the ability to objectively

Assessment of Non-Clinical PIP Methodology
evaluate project outcomes by failing to establish a clear starting point against which subsequent progress could be compared. ***The scoring element was not met.*** Scoring element **7.3** evaluated if the analysis assessed the statistical significance of any differences between the initial and repeat measurements. Three projects did not meet the requirement to assess the statistical significance of observed changes, resulting in a lack of mathematical evidence to confirm that differences between baseline and repeat measurements were the result of the intervention rather than random chance. ***The scoring element was not met.*** Scoring element **7.6** assessed if each PIP compared the results across multiple entities, such as different member subgroups, provider sites, or MCOs. Three projects did not meet the requirement to compare results across multiple entities or subgroups, which restricted the analysis to a single data set and prevented the identification of performance variations between different member populations, provider sites, or organizations. ***The scoring element was not met.*** Scoring element **7.7** evaluated if PIP results and findings were presented in a concise and easily understood manner. Five projects did not meet the requirement for concise and accessible reporting, as the results and findings were presented in a manner that was difficult to interpret, potentially obscuring key insights and limiting the ability of stakeholders to quickly grasp the project's impact. ***The scoring element was not met.***
Recommendations: Ensure that all future projects include a strictly defined baseline measurement period followed by consistent repeat measurements to provide a valid comparative analysis of project impact over time **(7.2)**. Integrate standardized statistical tests, such as p-value calculations or confidence intervals, into final evaluations to verify that any recorded improvements are statistically significant and represent genuine progress **(7.3)**. Design future analyses to include segmented data reporting, allowing for a side-by-side comparison of results across various subgroups or sites to better identify specific areas of success and opportunities for targeted improvement **(7.6)**. Utilize simplified data visualization tools and executive-style summaries to ensure that future findings are communicated clearly, focusing on essential metrics that are easily understood **(7.7)**.
Standard 8: Improvement Strategies
Strengths: None identified. See Appendix 2 for additional details on PIP interventions, including the effectiveness of each intervention used.
Weaknesses/Opportunities for Improvement: Scoring element **8.1** assessed if the selected improvement strategies were evidence-based. Five projects did not meet the requirement to demonstrate that the chosen improvement strategies were evidence-based, lacking a clear connection to established research or prior data to suggest the selected changes would logically result in the desired process or outcome improvements. ***The scoring element was not met).*** Scoring element **8.3** evaluated if a rapid-cycle PDSA approach was used to test the selected improvement strategies. Five projects did not meet the requirement to utilize the rapid-cycle PDSA approach, resulting in improvement strategies that were implemented without the iterative testing and incremental refinements necessary to validate effectiveness on a small scale before full implementation. ***The scoring element was not met.***

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Scoring element **8.6** assessed the extent to which the improvement strategies were successful and identified potential follow-up activities. Six projects did not fully meet the requirement to assess the overall success of the strategies based on data analysis, which resulted in a missed opportunity to clearly identify specific follow-up activities or lessons learned to guide the next phase of improvement. ***The scoring element was not met.***
Recommendations: Build upon existing planning processes by formally documenting the evidence base, whether from peer-reviewed literature, internal pilots, or industry best practices, that supports the likelihood of the selected intervention achieving its targeted goals **(8.1)**. Consistently apply the PDSA framework by conducting smaller, rapid test cycles that allow for real-time adjustments and data-driven evidence of success prior to broader scaling **(8.3)**. Explicitly link data interpretations to future strategic decisions, ensuring that every project conclusion includes a clear assessment of success and a roadmap for subsequent follow-up or scaling **(8.6)**.
Standard 9: Significant and Sustained Improvement
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Scoring element **9.1** evaluated if the same methodology was used for baseline and repeat measurements. Two projects did not fully meet the requirement to maintain a consistent methodology between baseline and repeat measurements. This inconsistency introduces potential bias or variables that can make it difficult to determine if changes in data reflect actual performance shifts or simply differences in how the data was collected and analyzed. ***The scoring element was not met.*** Scoring element **9.2** assessed if there was quantitative evidence of improvement in processes or outcomes of care. Five projects did not provide sufficient quantitative evidence to demonstrate measurable improvement in care processes or outcomes. While these initiatives may have made qualitative strides, the lack of definitive data points made it difficult to confirm whether the interventions led to the intended objective gains. ***The scoring element was not met.*** Scoring element **9.3** evaluated if the reported improvement in performance was likely to be a result of the selected intervention. Three of the nine projects did not meet the requirement to document a clear causal link between the selected intervention and the reported performance gains. ***The scoring element was not met.*** Scoring element **9.4** assessed if there was statistical evidence (e.g., significance tests) that any observed improvement was the result of the intervention. Two of the nine projects did not provide sufficient statistical evidence to confirm that the improvements observed were a direct consequence of the intervention. Without rigorous significance testing, such as p-values or confidence intervals, it remains unclear whether the positive shifts in data represent a true programmatic success or are simply the result of random variation. ***The scoring element was not met.***
Recommendations: Build upon existing data collection frameworks by establishing a methodology at the baseline stage that remains unchanged throughout all repeat measurement cycles **(9.1)**. Refine measurement frameworks to ensure the capture of specific quantitative data needed to validate improvement. Establishing clear, data-heavy performance indicators early will help projects more effectively demonstrate the tangible impact of the efforts on care outcomes **(9.2)**. Explicitly document how specific interventions directly influence the PIP improvements **(9.3)**.

Assessment of Non-Clinical PIP Methodology
Integrate formal statistical analysis into final reporting to validate that any recorded improvements are mathematically significant. Utilizing tools such as t-tests or Chi-square analysis will provide the necessary objective proof that the interventions, rather than chance, drove the change in performance **(9.4)**.

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

Table 19. Non-Clinical PIP Significant Improvement: Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Assessment of Non-Clinical PIP Significant Improvement
Significant Improvement
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Most of the reviewed projects did not achieve a high or moderate confidence rating, indicating that the evidence provided was insufficient to prove that the PIP produced statistically or operationally significant improvements in outcomes. This gap suggests that for many initiatives, the link between the intervention and a meaningful positive shift in performance was either weak or undocumented.
Recommendations: To increase the frequency of high-confidence outcomes, DHS and MCOs should focus on combining rigorous data collection, consistent methodology, and formal statistical significance testing. Future PIPs should be designed to move beyond anecdotal progress and instead provide a robust evidence package that clearly attributes significant improvements directly to the project's interventions.

Validation of Performance Improvement Project – Managed Care Organization Level Findings

Anthem Blue Cross and Blue Shield Health Plan

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

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

Clinical and Non-Clinical
Strengths
• Anthem conducted and reported detailed research regarding the topic selection and its importance to members. • Anthem clearly identified the clinical PIP population in relation to the aim statement.

Clinical and Non-Clinical
• Anthem selected clinical PIP variables and performance measures that were clear indicators of performance. • Anthem used valid and reliable procedures to collect the PIP data and inform its measurements. • Anthem used appropriate techniques to analyze the clinical PIP data and interpret the results. • Anthem selected and implemented an appropriate, evidence-based intervention that was likely to lead to the desired improvement for the clinical PIP. • Anthem detailed the effectiveness of all interventions used for the PIP. See Appendix 2 for additional details on PIP interventions.
Weaknesses/Opportunities for Improvement
• Scoring element 2.1 evaluated if the aim statements specified the improvement strategies. The improvement strategies were listed in a paragraph after the aim statements, not included within the aim statements. *This scoring element is not met.* • Scoring element 2.2 evaluated if the PIP population was clearly identified in the aim statements. It is unclear whether the study population includes all members within Milwaukee County or members connected with the Sixteenth Street Community Health Center. The aim statements did not clearly indicate to whom the PIP questions applied. *This scoring element is not met.* • Scoring element 2.2 evaluated if the PIP population was clearly identified in the aim statement. The aim statements did not clearly indicate to whom the PIP questions applied, specifically what MCO program each population is enrolled in (i.e. SSI, BC+, or both). *This scoring element is not met.* • Scoring element 2.4 assessed if the aim statements were concise. The aim statements contained an additional paragraph detailing the role of the Community Health Worker which detracted from the focus of the project. *This scoring element is not met.* • Scoring element 2.4 assessed if the aim statements were concise. The aim statements were not concise and did not clearly explain the project's basic framework. *This scoring element is not met.* • Scoring element 2.5 evaluated if the aim statements were answerable. The aim statement did not include the project's improvement strategy and a clearly defined population, which resulted in the aim statements not being answerable. *This scoring element is not met.* • Scoring element 2.6 assessed if the aim statements were measurable. Aim statement B did not contain a baseline measurement and therefore was not measurable. *This scoring element is not met.* • Scoring element 3.1 evaluated if the non-clinical project population was clearly defined in terms of the identified PIP question. The report outlined the numerator and denominator but did not include inclusion or exclusion criteria for the population. *This scoring element is not met.* • Scoring element 5.5 evaluated of the performance measures could monitor, track, and compare performance over time. Non-clinical data for Aim B was collected annually which did not allow for data to be monitored, tracked, or compared over the time of the project. *This scoring element is not met.* • Scoring element 7.2 assessed if the analysis included baseline and repeat measurements of the project outcomes. Baseline data was not provided for the non-clinical Aim B; therefore, analysis was not included. *This scoring element is not met.* • Scoring element 8.2 evaluated if the MCO planned how root causes and barriers would be identified. The non-clinical PIP did not identify a strategy that would address any barriers or root causes. *This scoring element is not met.*

Clinical and Non-Clinical
• Scoring element 8.3 assessed if a rapid-cycle PDSA approach was used to test the improvement strategy. A model of improvement to assess the ongoing effectiveness of the intervention was not documented in the non-clinical PIP. *This scoring element is not met.* • Scoring element 8.6 evaluated if the report assessed the extent to which the improvement strategy was successful and identified any potential follow-up activities. Potential follow-up activities were not identified in the non-clinical PIP. *This scoring element is not met.* • Scoring element 9.2 evaluated if the project demonstrated quantitative evidence of improvement in processes or outcomes of care. Aim statement B did not improve and showed a decline in rates. *This scoring element is not met.* • Scoring element 9.1 assessed if the same methodology was used for baseline and repeat measurements. Aim B did not provide a baseline measurement; therefore, the methodology could not be confirmed. *This scoring element is not met.* • Scoring elements 9.2 evaluated if there was quantitative evidence of improvement in processes or outcomes of care. Although the report indicated improvement, the MCO did not recognize that the initial and repeat measure could not be confirmed as comparable because no baseline measurement was documented for Aim B. *This scoring element is not met.* • Scoring element 9.3 assessed if the reported improvement in performance was likely to be a result of the selected intervention. The analysis indicated improvement but the MCO did not recognize the initial and repeat measure could not be confirmed as comparable and therefore any improvement in performance cannot be verified. *This scoring element is not met.* • Scoring element 9.4 evaluated if there was statistical evidence that the improvement was a result of the intervention. The report identified improvement, but the MCO did not recognize the initial and repeat measure could not be confirmed as comparable because no baseline measurement was documented for Aim B. *This scoring element is not met.*
Recommendations
• Include improvement strategies in the aim statement (2.1). • Clearly specify the population included in the project (2.2). • Ensure aim statements are concise and do not contain additional information (2.4). • Develop aim statements that are answerable and measurable (2.5, 2.6). • Clearly describe the study population including all inclusion and exclusion criteria (3.1). • Develop performance measures that monitor, track, and compare performance over time; and informed the selection and evaluation of quality improvement activities (5.5). • Ensure baseline and repeat measurement data is provided for all study questions (7.2). • Complete a PDSA cycle of the intervention to identify root causes or barriers and test the effectiveness of the improvement strategy (8.2, 8.3). • Identify any potential follow-up activities and ensure next steps are documented in the report (8.6). • Develop projects with interventions that are likely to lead to improvement (9.2). • Ensure baseline and repeat measurement data is provided for all study questions (9.1, 9.2, 9.3, 9.4).

Chorus Community Health Plan - Care4Kids

The following results provide an overview of the clinical and non-clinical PIPs submitted by CCHP - C4K.

Table 21. CCHP - C4K PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• C4K conducted and reported detailed research regarding the topic selection and its importance to members. • C4K established a clear, concise, measurable, and answerable aim statement. • C4K clearly identified the clinical PIP population in relation to the aim statement. • C4K selected clinical PIP variables and performance measures that were clear indicators of performance. • C4K used valid and reliable procedures to collect the PIP data and inform its measurements. • C4K used appropriate techniques to analyze the clinical PIP data and interpret the results. • C4K utilized methodology that was likely to demonstrate significant and sustained improvement in the non-clinical PIP.
Weaknesses/Opportunities for Improvement
• Scoring element 3.1 evaluated if the project population was clearly defined in terms of the identified PIP question. The aim statement identified the non-clinical PIP's population as any C4K's eligible and enrolled children under three years of age, with a positive developmental screen. The report's attachments defined the project's population as the total number of children enrolled in C4K who were referred to the Birth to 3 program. The report and report attachment contained inconsistent identification of the PIP population. *This scoring element is not met.* • Scoring element 5.1 assessed if the variables were adequate to answer the PIP question. The aim statement identified the project's measure as increasing successful referrals to the Birth to 3 program for all C4K members under the age of three with a positive developmental screen; however, Section 5 of the report defined the measure as the number of children evaluated for the program of all C4K children who were referred to the Birth to 3 program. The report contained inconsistent identification of the PIP variables and performance measures. *This scoring element is not met.* • Scoring element 7.7 evaluated if the PIP results and findings were presented in a concise and easily understood manner. The non-clinical PIP report, supplemental data documents, and interview presented conflicting information regarding the study population and PIP variables. The data analysis and interpretation of the PIP results were not easily understood. *This scoring element is not met.* • Scoring element 8.2 evaluated if the PIHP had a process in place to identify barriers that emerged during the project and how those barriers would be addressed. The report did not identify a planned process to assess the improvement strategy for barriers and to identify root causes. *This scoring element is not met.* • Scoring element 8.3 assessed if a PDSA cycle was completed during the project's implementation to evaluate the effectiveness of the intervention and make adjustment if necessary. The PIP report

Clinical and Non-Clinical
did not outline a PDSA cycle completed to evaluate the effectiveness of the intervention. *This scoring element is not met.* • Scoring element 8.4 evaluated of the intervention strategy was culturally and linguistically appropriate. The report did not identify how the intervention would meet the cultural and linguist needs of members. *This scoring element is not met.* • Scoring element 9.2 evaluated if the project produced quantitative evidence of improvement in processes or outcomes of care. Improvement was not demonstrated in the project. *This scoring element is not met.*
Recommendations
• Define an accurate and consistent study population that represents the denominator in at least one PIP variable (3.1). • Define variables that are consistent and will indicate performance on the study questions (5.1). • Present consistent data and information in all aspects of the PIP project to ensure results are concise (7.7). • Develop a strategy that is designed to address root causes or barriers identified through data analysis and quality improvement processes (8.2). • Implement a rapid-cycle PDSA approach to test improvement strategies (8.3). • Ensure interventions are culturally and linguistically appropriate and document it in the report (8.4). • Develop PIP projects with interventions that are likely to lead to quantitative evidence of improvement (9.2).

Chorus Community Health Plan

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

Table 22. CCHP PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• CCHP conducted and reported detailed research regarding the topic selection and its importance to members. • CCHP clearly identified the PIP population in relation to the aim statement. • CCHP selected clinical PIP variables and performance measures that were clear indicators of performance. • CCHP used valid and reliable procedures to collect the clinical PIP data and inform its measurements. • CCHP used appropriate techniques to analyze the clinical PIP data and interpret the results. • CCHP selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement. • CCHP detailed the effectiveness of all interventions used for the PIP. See Appendix 2 for additional details on PIP interventions.

Clinical and Non-Clinical
• CCHP utilized methodology that was likely to demonstrate significant and sustained improvement in the non-clinical PIP.
Weaknesses/Opportunities for Improvement
• Scoring element 2.2 required the PIP aim statement to clearly specify the population for the PIP. The aim statements identified the populations as non-engaged members with diabetes living in the target zip codes and non-engaged Black or African American members with diabetes living in the target zip codes. The PIP aim statements did not identify the population as BC+ members. *This scoring element is not met.* • Scoring element 2.4 required the PIP aim statement to be concise. The aim statement section of the report included extraneous information stating how goals for both aim statements were identified. *This scoring element is not met.* • Scoring element 2.4 required the PIP aim statement to be concise. The aim statement section of the report included extraneous information stating how goals for both aim statements were identified. *This scoring element is not met.* • Scoring element 2.5 evaluated if the aim statements were answerable by ensuring all needed components were part of the aim statements. CCHP did not clearly define the population for the PIP in the aim statements, which resulted in the statements not being answerable. *This scoring element is not met.* • Scoring element 5.1 evaluated if the variables were adequate to answer the PIP question. Non-clinical Aim statement A identified the PIP variables as the number of members with diabetes from the cohort without a completed office visit from January 1, 2024 through October 31, 2024 (numerator) and non-engaged diabetes member cohort (denominator). The numerator and denominator are synonymous, which makes the variables inadequate to answer the PIP question. *This scoring element is not met.* • Scoring element 6.5 required the data collection plan to link to the data analysis plan to ensure appropriate data would be available for the PIP. The non-clinical PIP identified data collection would occur monthly from February 2024 through October 2024, and data analysis would occur monthly beginning at the end of March 2024. The report did not identify data would be collected during November and December 2024, indicating a discrepancy between the data collection plan and the data analysis plan. *This scoring element is not met.* • Scoring element 7.1 required the data analysis to be conducted in accordance with the data analysis plan. The non-clinical PIP identified data would be collected and analyzed monthly from March 2024 to October 2024. During the interview, CCHP staff stated data collection and analysis occurred through February 2025 which was not specified in the report. *This scoring element is not met.* • Scoring element 7.7 required the PIP results and findings to be presented in a concise and easily understood manner. In the non-clinical PIP CCHP identified both aim statements were updated. However, the aim statements were not adjusted, leading to confusion with the information presented. *This scoring element is not met.* • Scoring element 9.5 evaluated if sustained improvement was demonstrated through repeated measurements over time. Although CCHP's CIS results reflected improvement in MY 2024, the results declined slightly from MY 2022 to MY 2023. Sustained improvement was not demonstrated over time. *This scoring element is not met.*
Recommendations

Clinical and Non-Clinical
• Ensure aim statements clearly specify the population for the PIP (2.2). • Ensure aim statements are concise and do not contain additional information (2.4). • Include all needed components in the aim statements to ensure they are answerable (2.5). • Ensure variables are adequate to answer the PIP question (5.1). • Develop a data collection plan that aligns with the data analysis plan to ensure appropriate data will be available for the PIP (6.5). • Ensure data analysis is conducted in accordance with the data analysis plan (7.1). • Amend the project's aim statements to align with changes identified in the PIP report to ensure results and findings are concise and easy to understand (7.7). • Ensure sustained improvement is demonstrated through repeated measurements over time (9.5).

Dean Health Plan, Inc.

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

Table 23. DHP PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• DHP conducted and reported detailed research regarding topic selection and its importance to members. • DHP established a clear, concise, measurable, and answerable aim statement in the clinical PIP. • DHP clearly identified the PIP population in relation to the aim statement. • DHP selected clinical PIP variables and performance measures that were clear indicators of performance. • DHP used valid and reliable procedures to collect the PIP data and inform its measurements. • DHP used appropriate techniques to analyze the PIP data and interpret the results. • DHP selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement in the clinical PIP. • DHP detailed the effectiveness of all interventions used for the PIP. See Appendix 2 for additional details on PIP interventions. • DHP utilized methodology that was likely to demonstrate significant and sustained improvement in the non-clinical PIP.
Weaknesses/Opportunities for Improvement
• Scoring element **2.3** required the PIP aim statement to include a clearly specified time period. The non-clinical aim statement does not reflect an exact end date in 2024 and thus, the timeline for the project is not clearly defined. *This scoring element is not met.* • Scoring element 2.5 required the PIP aim statement to be answerable. The non-clinical aim statement does not contain a clear end date which makes the aim statement unanswerable. *This scoring element is not met.* • Scoring element 5.9 required the PIP to include a strategy to ensure inter-rater reliability for manual data collection. Manual data collection was used in the non-clinical PIP without a documented

Clinical and Non-Clinical
process to ensure staff were entering the data accurately and consistently. *This scoring element is not met.* • Scoring element 8.1 required evidenced-based details to support the selection of the designated improvement strategies to guarantee the selected strategies would result in positive outcomes. Evidenced-based rationale was not documented in the non-clinical PIP for offering a gift card to members upon completion of the HNA as an improvement strategy. *This scoring element is not met.* • Scoring element 9.5 required the project to demonstrate sustained improvement through repeat measurements over time. The overall PPC rates declined in repeat measurement year two when compared to repeat measurement year one. *This scoring element is not met.*
Recommendations
• Include a clear and specified time period within the aim statement. If a project timeline will be a full calendar year, January through December, CY can be used. If a project utilizes a standard measurement with defined measurement years, such as a HEDIS® measurement, MY can be used. If the project timeline is for any other variation, the specific start and end dates need to be identified (2.3). • Ensure the aim statement is answerable by including a clearly identified end date for the project (2.5). • Document a process for inter-rater reliability when manual data collection occurs (5.9). • Document evidenced-based rationale to support the selection of each improvement strategy (8.1). • Ensure sustained improvement is demonstrated through repeat measurements over time (9.5).

Group Health Cooperative of Eau Claire

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

Table 24. GHC-EC PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• GHC-EC conducted and reported detailed research regarding the topic selection and its importance to members. • GHC-EC established a clear, concise, measurable, and answerable aim statement in the non-clinical PIP. • GHC-EC clearly identified the PIP population in relation to the aim statement. • GHC-EC selected clinical PIP variables and performance measures that were clear indicators of performance. • GHC-EC used valid and reliable procedures to collect the clinical PIP data and inform its measurements. • GHC- EC used appropriate techniques to analyze the clinical PIP data and interpret the results. • GHC-EC detailed the effectiveness of all interventions used for the PIP. See Appendix 2 for additional details on PIP interventions.

Clinical and Non-Clinical
• GHC-EC utilized methodology that was likely to demonstrate significant and sustained improvement in the non-clinical PIP.
Weaknesses/Opportunities for Improvement
• Scoring element 2.6 evaluated if the PIP aim statement was measurable. The goal identified in the clinical PIP aim statement of 65.38 percent for MY 2024 was lower than the FUH rate achieved in MY 2023 of 66.45 percent. The aim statement did not identify a goal for improvement over the previous year's results. *This scoring element is not met.* • Scoring element 5.1 assessed if the variables were adequate to answer the PIP question. The goal of the non-clinical project was to improve satisfaction survey completion rates for the non-English speaking SSI population. However, the numerator and denominator described in the report included all active SSI members. *This scoring element is not met.* • Scoring element 5.9 evaluated if the measures included a strategy to ensure interrater reliability. In the non-clinical PIP the MCO used the EHR to input results from completed satisfaction surveys and calculate survey completion rates. The report did not outline a clear strategy to ensure inter-rater reliability for manual data entry. *This scoring element is not met.* • Scoring element 6.13 evaluated if EHR data was used, member, clinical, service, or quality metrics were validated for accuracy and completeness as well as comparability across systems. The MCO used TruCare, an EHR, to input results from completed satisfaction surveys and calculate survey completion rates in the non-clinical PIP. The report did not outline a clear strategy to ensure metrics were validated for accuracy and completeness. *This scoring element is not met.* • Scoring element 7.8 assessed if the analysis and interpretation of PIP data included lessons learned about less-than-optimal performance. The MCO identified barriers related to sending surveys electronically; however, the report did not outline potential improvement opportunities in the non-clinical PIP. *This scoring element is not met.* • Scoring element 8.3 required the MCO to use the rapid-cycle PDSA approach to test the selected improvement strategy. The MCO identified that a PDSA was completed; however, the entirety of the PDSA cycle was not fully documented within the reports. *This scoring element is not met.* • Scoring element 9.2 evaluated if there was quantitative evidence of improvement in processes or outcomes of care. The MCO identified that there was no quantitative improvement as rates declined in MY 2024 from the baseline rate in MY 2022 for the clinical PIP. *This scoring element is not met.*
Recommendations
• Establish a goal that is an improvement over the rate obtained during the previous measurement year (2.6). • Ensure variables are adequate to answer the identified project question (5.1). • Include a strategy to ensure inter-rater reliability for manual data entry (5.9). • When EHR data is used, include a strategy to ensure metrics are validated for accuracy and completeness (6.13). • Include lessons learned or opportunities for improvement based on the data analysis when the aim is not achieved (7.8). • Document all steps of the PDSA cycle in future project reports (8.3). • Develop methodologically sound projects to demonstrate quantitative evidence of improvement (9.2).

Group Health Cooperative of South-Central Wisconsin

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

Table 25. GHC-SCW PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• GHC-SCW conducted and reported detailed research regarding the topic selection and its importance to members. • GHC-SCW established a clear, concise, measurable, and answerable non-clinical PIP aim statement. • GHC-SCW clearly identified the PIP population in relation to the aim statement. • GHC-SCW selected PIP variables and performance measures that were clear indicators of performance. • GHC-SCW used valid and reliable procedures to collect the PIP data and inform its measurements. • GHC-SCW used appropriate techniques to analyze the PIP data and interpret the results. • GHC-SCW detailed the effectiveness of all interventions used for the PIP. See Appendix 2 for additional details on PIP interventions. • GHC-SCW utilized methodology that was likely to demonstrate significant and sustained improvement.
Weaknesses/Opportunities for Improvement
• Scoring element 2.6 evaluated if the aim statement was measurable. The goal identified in the clinical aim was to eliminate the COL disparity rate. The aim statement did not include a defined numeric measurement goal. *This scoring element is not met.* • Scoring element 8.1 required that improvement strategies were evidence based. The MCO did not provide information in the non-clinical PIP report to show how each strategy was evidence based and would likely lead to improvement in outcomes. *This scoring element is not met.* • Scoring element 8.3 required the MCO to use the rapid-cycle PDSA approach to test the selected improvement strategy. The MCO identified that a PDSA would be completed; however, the entirety of the PDSA cycle was not fully documented within the clinical PIP report. *This scoring element is not met.*
Recommendations
• Ensure the aim statement includes a defined numeric measurement goal (2.6). • Ensure selected improvement strategies are evidence based (8.1). • Document all steps of the PDSA cycle in future project reports (8.3).

Independent Care Health Plan

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

Table 26. *i*Care PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• *i*Care conducted and reported detailed research regarding the topic selection and its importance to members. • *i*Care established a clear, concise, measurable, and answerable non-clinical aim statement. • *i*Care clearly identified the PIP population in relation to the aim statement. • *i*Care selected PIP variables and performance measures that were clear indicators of performance. • *i*Care used valid and reliable procedures to collect the PIP data and inform its measurements. • *i*Care used appropriate techniques to analyze the PIP data and interpret the non-clinical results.
Weaknesses/Opportunities for Improvement
• Scoring element 2.1 required the PIP aim statement to include an improvement strategy. The clinical aim statement made a general reference to the use of an improvement strategy and did not identify the specific strategy to be used to achieve the aim. *This scoring element is not met.* • Scoring element 2.5 required the PIP aim statement to include the improvement strategy, population, and time period to guarantee the aim statement is answerable. The clinical aim statement did not identify the specific improvement strategy to be used to achieve the aim and therefore, the aim statement is not answerable. *This scoring element is not met.* • Scoring element 2.6 required the PIP aim statement to reflect a goal for improvement to ensure the aim statement is measurable. The baseline rate outlined in the aim statement was 18.6 percent based on the HEDIS® HBD measure. The HBD measure was retired during the course of the project and replaced by the HEDIS® GDS measure. The MCO updated the baseline rate to 43.14 percent to reflect updated HEDIS® measure, however the aim statement's goal rate was not updated to reflect a goal for improvement. *This scoring element is not met.* • Scoring element 7.3 required the PIP report to assess the statistical significance of any differences between initial and repeat measurements. The clinical PIP report solely contained a statistical significance test for the process measure. Statistical significance testing was not completed for the aim statement to assess differences between initial and repeat measurements. *This scoring element is not met.* • Scoring element 8.6 required the PIP report to evaluate the effectiveness of improvement strategies and to identify potential follow-up activities. Follow-up activities were not detailed in the report. *This scoring element is not met.* • *i*Care did not detail the effectiveness of all interventions used for the PIP. See Appendix 2 for additional details on PIP interventions. • Scoring element 9.1 required the PIP report to use the same methodology for baseline and repeat measurements. The original aim baseline rate of 18.6 percent was changed to 43.14 percent to reflect the updated HEDIS® measure; however, the aim statement was not updated to reflect this change. The baseline rate was not consistent with the repeat measure and therefore, the measures were not comparable. *This scoring element is not met.* • Scoring element 9.2 required the PIP report to contain quantitative evidence of improvement in processes or outcomes of care. The report identified improvement; however, the baseline rate was not consistent with the repeat measure and the MCO did not recognize the difference. *This scoring element is not met.*

Clinical and Non-Clinical
• Scoring element 9.3 required the PIP report to detail whether the reported improvement in performance was likely to be the result of the selected intervention. The report did not outline the effectiveness of one of the identified improvement strategies, and the MCO did not recognize the initial and repeat measures were not comparable. *This scoring element is not met.* • Scoring element 9.4 required the PIP report to assess statistical evidence that any observed improvement is the result of the selected intervention. Statistical significance testing was completed on a process measure and not completed for the aim statement to determine if the improvement achieved can mathematically be attributed to the interventions. *This scoring element is not met.* • Scoring element 9.5 required the PIP report to demonstrate sustained improvement through repeat measurements over time. The revised baseline rate was higher than the projected goal identified within the aim statement and therefore, sustained improvement could not be accurately measured. *This scoring element is not met.*
Recommendations
• Ensure aim statements include specific improvement strategies (2.1, 2.5). • Update aim statements to reflect a goal for improvement (2.6). • Conduct statistical significance testing for aim statements (7.3). • Evaluate the effectiveness of all improvement strategies and identify potential follow-up activities based on the data analysis and interpretation of PIP results (8.6). • Update the aim statement to reflect an accurate baseline rate to guarantee baseline and repeat measures are comparable (9.1, 9.2, 9.3, 9.4, 9.5). • Evaluate the effectiveness of all identified improvement strategies to document the impact the improvement strategies had on the success of the project (9.3). • Conduct statistical significance testing on the aim statement to determine if the improvement achieved can mathematically be attributed to the interventions (9.4). • Update the projected goal for improvement in the aim statement to be higher than the identified baseline rate if the baseline rate changed in the measurement year (9.5).

MercyCare Health Plan

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

Table 27. MCHP PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• MCHP conducted and reported detailed research regarding the topic selection and its importance to members. • MCHP established a clear, concise, measurable, and answerable clinical PIP aim statement. • MCHP clearly identified the PIP population in relation to the non-clinical aim statement. • MCHP used valid and reliable procedures to collect the clinical PIP data and inform its measurements.

Clinical and Non-Clinical
• MCHP selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement for the non-clinical PIP. • MCHP detailed the effectiveness of all interventions used for the non-clinical PIP. See Appendix 2 for additional details on PIP interventions. • MCHP utilized methodology that was likely to demonstrate significant and sustained improvement for the non-clinical PIP.
Weaknesses/Opportunities for Improvement
• Scoring element 2.2 required the PIP aim statement to clearly specify the population for PIP. The non-clinical PIP aim statement identified the population as members over the age of 18 who reported that the staff at their usual clinic met racial, cultural, and language needs. The PIP aim statement did not identify the population as BC+ members. *This scoring element is not met.* • Scoring element 2.5 evaluated if the aim statement was answerable by ensuring all needed components were part of the aim statement. MCHP did not clearly define the population in the aim statement for the non-clinical PIP; which resulted in the statement not being answerable. *This scoring element is not met.* • Scoring element 3.1 required the project population to be clearly defined in terms of the identified PIP question. The clinical project population was defined as all active Medicaid members two years old and younger meeting the HEDIS® MY 2024 CIS-E specifications. The project population does not align with the population outlined in the aim statement, which focuses on non-White BC+ members. *This scoring element is not met.* • Scoring element 5.1 required the variables to be adequate to answer the PIP question. The project's variables did not focus on the non-White BC+ population, resulting in a misalignment with the aim statement. *This scoring element is not met.* • Scoring element 5.5 evaluated if the performance measures could monitor, track, and compare performance over time. Data for the aim was collected annually which did not allow for data to be monitored, tracked, or compared over the time of the project. *This scoring element is not met.* • Scoring element 5.9 evaluated if the measures included a strategy to ensure interrater reliability. MCHP confirmed during the interview that data collected from member surveys received in paper form was manually entered into the Access database by a Quality Analyst. The data is checked for accuracy by another MCHP staff member; however, this information was not included in the report. *This scoring element is not met.* • Scoring element 6.13 evaluated if electronic health record data was used, that member, clinical, services, or quality metrics were validated for accuracy and completeness as well as comparability across systems. During the interview, MCHP staff confirmed non-clinical PIP data from the member survey is obtained through an automated query from the electronic health record system, and data was validated for accuracy and completeness. This information was not included in the report. *This scoring element is not met.* • Scoring element 7.3 evaluated if an analysis was completed to assess the statistical significance of any differences between the initial and repeat measurements. Statistical testing was completed on the HEDIS® CIS-E rate for the BC+ population; however, no statistical testing was completed for the non-White BC+ population identified in the aim statement. *This scoring element is not met.*

Clinical and Non-Clinical
• Scoring element 7.6 evaluated if the PIP compared the results across multiple entities, such as different member subgroups, provider sites, or MCOs. The PIP did not compare the results across other entities or subgroups. *This scoring element is not met.* • Scoring element 7.7 required the PIP results and findings to be presented in a concise and easily understood manner. The clinical project's aim statement identified the project population as non-White BC+ members; however, the baseline rate included in the aim statement was for all BC+ members. Throughout the report, the project focused on the HEDIS® CIS-E rate for all BC+ members, which does not align with the aim statement, leading to confusion with the information presented. *This scoring element is not met.* • Scoring element 7.7 evaluated if the PIP results and findings were presented in a concise and easily understood manner. The non-clinical PIP report stated the member survey deployed in January 2025 measured member experience between January 1, 2025 and December 31, 2025. This date error led to confusion with the information presented. *This scoring element is not met.* • Scoring element 8.6 evaluated if the report assessed the extent to which the improvement strategies were successful and identified any potential follow up activities. The clinical PIP report identified the effectiveness of the improvement strategies for the overall BC+ population, but did not assess the effectiveness of the improvement strategies for the non-White population identified in the aim statement. *This scoring element is not met.* • Scoring element 9.3 assessed if the reported improvement in performance was likely to be a result of the selected interventions. The report identified the role the interventions had on the success of the project for the overall BC+ population, but did not describe the role the interventions had for the non-White population identified in the aim statement. *This scoring element is not met.* • Scoring element 9.4 evaluated if there was statistical evidence that any observed improvement was the result of the intervention. The report identified statistical significance testing was completed on the CIS-E measurements for the overall BC+ population, but did not indicate statistical testing was completed on the CIS-E rate for the non-White population. *This scoring element is not met.* • Scoring element 9.5 evaluated if sustained improvement was demonstrated through repeated measurements over time. The HEDIS® CIS-E rates for the non-White population declined from MY 2023 to MY 2024, indicating sustained improvement was not demonstrated over time. *This scoring element is not met.*
Recommendations
• Ensure the aim statement clearly specifies the population for the PIP (2.2). • Include all needed components in the aim statement to ensure it is answerable (2.5). • Create an aim statement that aligns with the project population to ensure the project population is clearly defined (3.1). • Create an aim statement that aligns with the project's variables and population to ensure the variables are adequate to answer the PIP question (5.1). • Develop performance measures that monitor, track, and compare performance over time; and inform the selection and evaluation of quality improvement activities (5.5). • Document the strategy to ensure interrater reliability in the PIP report (5.9). • Ensure the process for validating data collected from the electronic health record for accuracy and completeness is included in the PIP report (6.13).

Clinical and Non-Clinical
• Create an aim statement that aligns with the project's variables and population to ensure accurate statistical analysis between initial and repeat measurements, and to ensure results and findings are concise and easy to understand (7.3, 7.7). • Ensure the PIP results are compared across multiple entities such as different member subgroups, provider sites, or MCOs (7.6). • Create an aim statement that aligns with the project's variables and population to ensure accurate assessment of the effectiveness of the improvement strategies (8.6). • Create an aim statement that aligns with the project's variables and population to ensure accurate assessment of the effectiveness of the improvement strategies (9.3, 9.4). • Ensure sustained improvement is demonstrated through repeated measurements over time (9.5).

MHS Health Wisconsin

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

Table 28. MHS PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• MHS conducted and reported detailed research regarding the topic selection and its importance to members. • MHS established clear, concise, measurable, and answerable aim statements. • MHS clearly identified the PIP population in relation to the aim statements. • MHS selected clinical PIP variables and performance measures that were clear indicators of performance. • MHS used valid and reliable procedures to collect the PIP data and inform its measurements. • MHS used appropriate techniques to analyze the PIP data and interpret the results. • MHS selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement. • MHS detailed the effectiveness of all interventions used for the PIP. See Appendix 2 for additional details on PIP interventions. • MHS utilized methodology that was likely to demonstrate significant and sustained improvement in the non-clinical PIP.
Weaknesses/Opportunities for Improvement
• Scoring element 5.1 evaluated if the variables were adequate to answer the PIP question. The non-clinical PIP report did not clearly define a variable to measure the PIP aim statement. While the aim statement outlined the focus of the project, the report narrative focused on process measures, making it unclear on how the aim statement would be measured. During the interview, MHS staff identified the PIP variable; however, this information was not included in the report. *This scoring element is not met.* • Scoring element 9.2 assessed if there was quantitative evidence of improvement in processes or outcomes of care. Improvement was not demonstrated for either one of the clinical aim statements.

Clinical and Non-Clinical
Rates declined from MY 2023 to MY 2024 for the HEDIS® FUM-30 measure and the HEDIS® FUH-30 measure. *This scoring element is not met.*
Recommendations
• Clearly define variables that measure the PIP aim statement (5.1). • Develop projects with interventions that are likely to lead to improvement (9.2).

Molina Healthcare of Wisconsin, Inc.

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

Table 29. MHWI PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• MHWI conducted and reported detailed research regarding the topic selection and its importance to members. • MHWI established a clear, concise, measurable, and answerable clinical PIP aim statement. • MHWI clearly identified the PIP population in relation to the aim statement. • MHWI selected clinical PIP variables and performance measures that were clear indicators of performance. • MHWI used valid and reliable procedures to collect the PIP data and inform its measurements. • MHWI used appropriate techniques to analyze the PIP data and interpret the results. • MHWI detailed the effectiveness of all interventions used for the clinical PIP. See Appendix 2 for additional details on PIP interventions.
Weaknesses/Opportunities for Improvement
• Scoring element 2.2 evaluated if the PIP aim statement clearly specified the population of the PIP. The non-clinical aim statement did not identify BC+ members. *This scoring element is not met.* • Scoring element 2.5 evaluated if the PIP aim statement was answerable. The BC+ population was not explicitly identified in the non-clinical aim statement; therefore, the aim statement is not answerable. *This scoring element is not met.* • Scoring element 5.1 evaluated if the variables were adequate to answer the PIP question. The non-clinical PIP numerator included all Molina members who rated Molina with a score of nine or 10 rather than explicitly indicating BC+ members only. *This scoring element is not met.* • Scoring element 8.1 required the MCO to select evidence-based improvement strategies. The MCO did not identify existing evidence suggesting providing a gift card to members who attested to completing cervical cancer screening would likely lead to desired improvement in outcomes. *This scoring element is not met.* • Scoring element 8.6 evaluated if the PIP assessed the extent to which the improvement strategy was successful and if potential follow-up activities were identified. MHWI included an evaluation of the non-clinical PIP intervention's impact on process measures; however, it did not incorporate an assessment of the intervention's effectiveness on CAHPS® scores. See Appendix 2 for additional details on PIP interventions. *This scoring element is not met.*

Clinical and Non-Clinical
• Scoring element 9.2 evaluated if there was quantitative evidence of improvement in processes or outcomes of care. The MCO identified that there was no quantitative improvement as rates declined in MY 2024 from the baseline rate in MY 2023. *This scoring element is not met.* • Scoring element 9.3 evaluated if the reported improvement was likely to be a result of the selected intervention. MHWI did not detail the effectiveness of the interventions on the CAHPS® results. *This scoring element is not met.*
Recommendations
• Clearly define the population in the aim statement (2.2). • Ensure the aim statement includes all required criteria (2.5). • Ensure the variables are adequate to answer the PIP question (5.1). • Ensure improvement strategies are evidence-based (8.1). • Assess and describe the effectiveness of each improvement strategy in future reports (8.6). • Develop methodologically sound projects to demonstrate quantitative evidence of improvement (9.2). • Ensure project improvement is the result of the intervention (9.3).

Network Health Plan

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

Table 30. NHP PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• NHP conducted and reported detailed research regarding the topic selection and its importance to members. • NHP established a clear, concise, measurable, and answerable aim statement. • NHP clearly identified the PIP population in relation to the clinical PIP aim statement. • NHP selected clinical PIP variables and performance measures that were clear indicators of performance. • NHP used valid and reliable procedures to collect the PIP data and inform its measurements. • NHP used appropriate techniques to analyze the clinical PIP data and interpret the results. • NHP selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement. • NHP detailed the effectiveness of all interventions used for the PIP. See Appendix 2 for additional details on PIP interventions. • NHP utilized methodology that was likely to demonstrate significant and sustained improvement in the non-clinical PIP.
Weaknesses/Opportunities for Improvement
• Scoring element 3.1 evaluated if the project population was clearly defined in terms of the identified PIP question. The non-clinical PIP population was defined as NHP members with a DOH need in rural counties. The aim statement defined the PIP population as SSI non-dual members in rural counties. The PIP population required members to have a DOH need and did not identify

Clinical and Non-Clinical
members as SSI non-dual members, which does not align with the population defined in the aim statement. *This scoring element is not met.* • Scoring element 5.1 required the variables to be adequate to answer the PIP question. The non-clinical PIP report did not clearly define a variable to measure the PIP aim statement. While the aim statement outlined the focus of the project, the report narrative focused on process measures, making it unclear on how the aim statement would be measured. During the interview, NHP staff identified the PIP variable; however, this information was not included in the report. *This scoring element is not met.* • Scoring element 7.7 evaluated if the PIP results and findings were presented in a concise and easily understood manner. The non-clinical PIP report identified there were more assessments completed than there were unique members for the project. During the interview, the MCO explained that some members had multiple DOH screening assessments completed during the measurement year. However, this was not explained in the report. *This scoring element is not met.* • Scoring element 9.2 evaluated if there was quantitative evidence of improvement of care or outcomes of care. NHP did not demonstrate an improvement in the PPC HEDIS® rate from MY 2023 to MY 2024. *This scoring element is not met.* • Scoring element 9.5 required the project to demonstrate sustained improvement through the repeated measurements over time. PPC has been a continuing PIP topic since 2021; NHP did not demonstrate improvement for the clinical PIP aim statement for each project year. *This scoring element is not met.*
Recommendations
• Ensure the PIP population is clearly defined according to the aim statement (3.1). • Ensure the PIP report includes a detailed variable that is adequate to answer the PIP question/aim statement (5.1). • Ensure PIP results and findings are presented in a clear and easily understood manner (7.7). • Develop projects with interventions that are likely to lead to improvement (9.2). • Ensure sustained improvement is demonstrated through repeat measurements over time (9.5).

Quartz Health Solutions, Inc.

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

Table 31. Quartz PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• Quartz conducted and reported detailed research regarding the clinical PIP topic selection and its importance to members. • Quartz established a clear, concise, measurable, and answerable clinical PIP aim statements. • Quartz clearly identified the PIP population in relation to the aim statements.

Clinical and Non-Clinical
• Quartz selected PIP variables and performance measures that were clear indicators of performance. • Quartz used valid and reliable procedures to collect the non-clinical PIP data and inform its measurements. • Quartz used appropriate techniques to analyze the non-clinical PIP data and interpret the results. • Quartz selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement in the clinical PIP. • Quartz detailed the effectiveness of all interventions used for the clinical PIP. See Appendix 2 for additional details on PIP interventions. • Quartz utilized methodology that was likely to demonstrate significant and sustained improvement for the clinical PIP.
Weaknesses/Opportunities for Improvement
• Scoring element 1.3 required the PIP to include topic selection input from enrollees or providers. The non-clinical PIP report did not contain provider or enrollee input in the PIP's topic selection. *This scoring element is not met.* • Scoring element 2.3 required the PIP aim statements to include a clearly specified time period. The non-clinical PIP aim statements do not reflect an exact end date in 2024 and thus, the timeline for the project is not clearly defined. *This scoring element is not met.* • Scoring element 2.4 required the PIP aim statements to be concise. The non-clinical PIP aim statement section of the report included extraneous information stating how goals for all aim statements were identified. *This scoring element is not met.* • Scoring element 2.5 required the PIP aim statements to be answerable. The non-clinical PIP aim statements do not contain a clear end date which makes the aim statements unanswerable. *This scoring element is not met.* • Scoring element 6.2 required the PIP to specify the planned frequency of data collection. The frequency of data collection was not identified in the clinical PIP report. *This scoring element is not met.* • Scoring element 6.5 required the PIP to align the data collection plan with the data analysis plan to guarantee the appropriate data would be available for the PIP. The frequency of data collection was not identified in the clinical PIP report; therefore, the proposed data collection and data analysis plan could not be compared to ensure the appropriate data would be available for the PIP. *This scoring element is not met.* • Scoring element 7.7 required the PIP results and findings to be presented in a concise and easily understood manner. The body of the clinical PIP report contained an inconsistent baseline measurement year that contradicted the baseline measurement year documented in all aim statements. *This scoring element is not met.* • Scoring element 8.1 required evidenced-based details to support the selection of the designated improvement strategies to guarantee the selected strategies would result in positive outcomes. Evidenced-based rationale was not documented in the non-clinical PIP for increased telephonic outreach attempts by the care management department, or the offer of a gift card to members upon completion of the HRA. *This scoring element is not met.* • Scoring element 8.3 required the PIP report to conduct and document a rapid-cycle PDSA approach to identify whether the interventions are effective, or if project adjustments are needed. A rapid-

Clinical and Non-Clinical
cycle PDSA approach was not documented in the non-clinical PIP report. *This scoring element is not met.* • Scoring element 8.6 required the PIP report to evaluate the effectiveness of improvement strategies and to identify potential follow-up activities. The evaluation of the effectiveness of the identified improvement strategies was not outlined in the non-clinical PIP report. *This scoring element is not met.* • Scoring element 9.2 required the PIP report to contain quantitative evidence of improvement in processes or outcomes of care. Improvement was not achieved for Quartz's overall Medicaid SSI population in the non-clinical PIP. *This scoring element is not met.*
Recommendations
• Obtain and document input from enrollees or providers to identify the selection of the PIP topic (1.3). • Include a clear and specified time period within the aim statement. If a project timeline will be a full calendar year, January through December, CY can be used. If a project utilizes a standard measurement with defined measurement years, such as a HEDIS® measurement, MY can be used. If the project timeline is for any other variation, the specific start and end dates are to be identified (2.3). • Ensure aim statements are concise and do not contain additional information (2.4). • Ensure the aim statements are answerable by including a clearly identified end date for the project (2.5). • Document the planned frequency of data collection in the report (6.2, 6.5). • Document a consistent baseline measurement year in the report that aligns with the aim statements (7.7). • Document evidenced-based rationale to support the selection of each improvement strategy (8.1). • Conduct and document a rapid-cycle PDSA approach to test the selection of the improvement strategies, and to determine if project adjustments are needed (8.3). • Evaluate the effectiveness of all identified improvement strategies in the report (8.6). • Demonstrate improvement from the baseline rate for all aim statements (9.2).

Security Health Plan of Wisconsin

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

Table 32. SHP PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• SHP conducted and reported detailed research regarding the topic selection and its importance to members. • SHP clearly identified the PIP population in relation to the aim statement. • SHP selected PIP variables and performance measures that were clear indicators of performance. • SHP used valid and reliable procedures to collect the PIP data and inform its measurements. • SHP used appropriate techniques to analyze the clinical PIP data and interpret the results.

Clinical and Non-Clinical
• SHP selected and implemented appropriate, evidence-based interventions that were likely to lead to the desired improvement in the clinical. • SHP detailed the effectiveness of all interventions used for the PIP. See Appendix 2 for additional details on PIP interventions. • SHP utilized methodology that was likely to demonstrate significant and sustained improvement in the clinical PIP.
Weaknesses/Opportunities for Improvement
• Scoring element 2.1 evaluated if the aim statement clearly identified the improvement strategy. The MCO identified a list of interventions in the aim statement section of the report; however, improvement strategies were not included in the aim statement itself. *This scoring element is not met.* • Scoring element 2.2 evaluated if the aim statement clearly specified the population for the PIP. The aim statement did not identify the SHP BC+ line of business to define members as part of the project's population. *This scoring element is not met*. • Scoring element 2.4 evaluated if the PIP aim statement was concise. The aim statement section of the PIP report included three paragraphs and included additional information that detracted from the goal of the project. *This scoring element is not met.* • Scoring element 2.5 evaluated if the aim statement was answerable. The MCO did not specify the BC+ population as part of the aim statement; therefore, the aim statement was not answerable. *This scoring element is not met.* • Scoring element 7.3 assessed the statistical significance of any differences between the initial and repeat measures. The report indicated that a statistical significance analysis showed an increase in screening completion. However, it did not provide evidence that formal statistical testing was conducted for the project. *This scoring element is not met.* • Scoring element 8.3 required the MCO to use the rapid-cycle PDSA approach to test the selected improvement strategy. The MCO identified that a PDSA cycle was completed; however, the entirety of the PDSA cycle was not fully documented within the non-clinical PIP report. *This scoring element is not met.* • Scoring element 9.4 evaluated if there was statistical evidence that any observed improvement was the result of the interventions. The non-clinical PIP report indicated that screening completion rates increased from 2023 to 2024, but the MCO did not complete statistical testing to determine if the rate of improvement was the result of the interventions. *This scoring element is not met.*
Recommendations
• Include the project's improvement strategy in future aim statements (2.1). • Ensure the aim statement clearly specifies the population for the project (2.2). • Ensure the aim statement is concise (2.4). • Identify the population within the aim statement to ensure the aim statement is answerable (2.5). • Conduct statistical testing and include findings from the test when analyzing PIP results (7.3). • Document all steps of the PDSA cycle in future project reports (8.3). • Include statistical evidence that any observed improvement is the result of the interventions (9.4).

UnitedHealthcare Community Plan

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

Table 33. UHC PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Clinical and Non-Clinical
Strengths
• UHC conducted and reported detailed research regarding the topic selection and its importance to members. • UHC established a clear, concise, measurable, and answerable clinical PIP aim statement. • UHC clearly identified the PIP population in relation to the aim statement. • UHC selected clinical PIP variables and performance measures that were clear indicators of performance. • UHC used valid and reliable procedures to collect the clinical PIP data and inform its measurements. • UHC used appropriate techniques to analyze the clinical PIP data and interpret the results.
Weaknesses/Opportunities for Improvement
• Scoring element 2.3 required the PIP aim statements to clearly specify a time period for the PIP. The non-clinical PIP aim statement did not clearly specify a start date and end date. The PIP utilized MY as the timeframe; however, the MY for the project was not defined. If a project timeline is a full calendar year, January through December, CY can be used. If a project utilizes a standard measurement with defined measurement years, such as a HEDIS® measurement when a HEDIS® measurement is the variable, MY can be used. If the project timeline is any other variation, the specific start and end dates are to be identified. *This scoring element is not met.* • Scoring element 2.5 evaluated if the aim statements were answerable. The MCO did not specify a start date or end date as a part of the non-clinical PIP aim statements; therefore, the aim statements were not answerable. *This scoring element is not met.* • Scoring element 5.1 evaluated whether the variables were adequate to answer the PIP question. The non-clinical aim statement indicated the variable was the food insecurity screening rate. However, the report limited the population to members with diabetes who had a HEDIS® GSD result of <8.0 percent and who answered "yes" to the food insecurity question. The numerator combined the screening rate with glycemic control, which does not align with the aim statement. The aim does not require a specific HEDIS® GSD result or a "yes" response to the screening question, only that screening occurred. *This scoring element is not met*. • Scoring element 6.13 required that member, clinical, service, or quality metrics were validated for accuracy and completeness as well as comparability across systems when using electronic health record data. The non-clinical PIP report did not outline the method utilized to ensure data from the electronic health record was validated to ensure accuracy and completeness. *This scoring element was not met.* • Scoring element 7.3 required the analysis to include the assessed statistical significance of any differences between the initial and repeat measurements. Statistical analysis of food insecurity screening rates was not completed individually for the BC+ and SSI populations for the non-clinical PIP. *This scoring element is not met.*

Clinical and Non-Clinical
• Scoring element 7.6 required the MCO to compare results across multiple entities such as different member subgroups, provider sites, or MCOs. Food insecurity screening rates were not compared across other entities or subgroups for the non-clinical PIP. *This scoring element is not met.* • Scoring element 7.7 evaluated if results and findings were presented in a concise and easily understood manner. While the aim statement used HEDIS® GSD specifications to define the population of the non-clinical PIP, the GSD measure was not the aim of the project. Throughout the non-clinical PIP report, GSD results were included and presented as the focus of the report, rather than the stated goal of improving food insecurity screening rates. *This scoring element is not met.* • Scoring element 8.1 required the MCO to select evidence-based improvement strategies. In the PIP report, the MCO did not identify existing evidence suggesting that phone screenings, providing food, partnering with local grocery stores, or incentivizing attending diabetic care appointments are likely to lead to an improvement in food insecurity screening rates. *This scoring element is not met.* • Scoring element 8.5 evaluated if the implementation of the strategy was designed to account for any major confounding variables that could have an obvious impact on PIP outcomes. UHC identified barriers with members utilizing Wellhop, including reluctance to download an application and to engage in a virtual platform. UHC also identified a barrier of lapses in coverage for members due to Pomelo no longer partnering with Wisconsin Doulas of Color Collective. The report did not indicate how these barriers were addressed. *This scoring element is not met.* • Scoring element 8.6 evaluated if the PIP assessed the extent to which the improvement strategy was successful and if potential follow-up activities were identified. UHC evaluated if phone outreach was impactful on food insecurity screening rates; however, it did not evaluate the effect of providing food, partnering with local grocery stores, and incentivizing attending diabetic care appointments on food insecurity screening rates. *This scoring element is not met.* • Scoring element 9.2 evaluated if there was quantitative evidence of improvement in processes or outcomes of care. The MCO identified that there was no quantitative improvement in the SSI population as rates declined in MY 2024 from the baseline rate in MY 2022. *This scoring element is not met.* • Scoring element 9.5 evaluated if sustained improvement was demonstrated through repeated measurements over time. While the project achieved its goal in MY 2024, the report indicated that there was an increase in the Index of Disparity between MY 2022 and MY 2023, indicating improvement for the project was not sustained over time. *This scoring element is not met.*
Recommendations
• Include a clearly specified time period within the aim statement (2.3). • Ensure the aim statement includes a specified time period to ensure it is answerable (2.5). • Ensure the PIP aim statement variables align with numerator and denominator measures (5.1). • Include the strategies utilized to validate accuracy and completeness of data as well as comparability across systems in the PIP report (6.13). • Ensure analysis of statistical significance between initial and repeat measurements is completed for each aim statement population individually (7.3). • Compare results across multiple entities or subgroups in future PIP reports (7.6). • Present results and findings in a concise and easily understood manner (7.7). • Ensure improvement strategies are evidenced-based (8.1).

Clinical and Non-Clinical
• Ensure strategies are designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (8.5). • Assess and describe the effectiveness of each improvement strategy in future reports (8.6). • Develop methodologically sound projects to demonstrate quantitative evidence of improvement (9.2). • Demonstrate sustained improvement in repeat measurements over time (9.5).

Wraparound Milwaukee

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

Table 34. WM PIP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Non-Clinical
Strengths
• WM conducted and reported detailed research regarding the topic selection and its importance to members. • WM clearly identified the PIP population in relation to the aim statement.
Weaknesses/Opportunities for Improvement
• Scoring element 2.1 evaluated if the aim statement clearly specified the improvement strategy. The aim statement did not include an improvement strategy. *This scoring element is not met.* • Scoring element 2.3 required the PIP aim statement to include a clearly specified time period. The aim statement did not include a clear start date for the project making the timeline for the project not clearly defined. *This scoring element is not met.* • Scoring element 2.5 required the PIP aim statement to be answerable. The aim statement did not include an improvement strategy or a clear start date which made the aim statement unanswerable. *This scoring element is not met.* • Scoring element 2.6 assessed if the aim statement was measurable. The aim statement did not contain a baseline measurement making the project not measurable. *This scoring element is not met.* • Scoring element 5.1 evaluated if the variables were adequate to answer the PIP question. The report identified each youth's disenrollment reason as the project's numerator and the total number of youth disenrolled from the PIHP as the denominator. The variables do not align with the aim statement, which makes them inadequate to answer the PIP question. *This scoring element is not met.* • Scoring element 5.2 evaluated if the performance measure assessed an important aspect of care that will make a difference to enrollees' health or functional status. The PIP's aim statement was focused on youth disenrolling from the PIHP and not related to continuity of care or improving any aspect of care to youth. *This scoring element is not met.* • Scoring element 6.13 evaluated if electronic health record data was used, that member, clinical, services, or quality metrics were validated for accuracy and completeness. The report indicated disenrollment data was compiled monthly from Synthesis, WM's electronic health record system,

Non-Clinical
but does not describe how the data was validated for accuracy and completeness. *This scoring element is not met.* • Scoring element 7.2 assessed if the analysis included baseline and repeat measurements of the project outcomes. Baseline data was not provided for the aim statement; therefore, analysis was not included. *This scoring element is not met.* • Scoring element 7.3 required an analysis of the statistical significance of any differences between the initial and repeat measurement. The project did not include an analysis of statistical significance between initial and repeat measurements. *This scoring element is not met.* • Scoring element 7.4 evaluated if the analysis accounted for factors that may influence the comparability of initial and repeat measurements. The project did not include an analysis of factors that may influence the comparability of initial and repeat measurements. *This scoring element is not met.* • Scoring element 7.5 evaluated if the analysis accounted for factors that may threaten the internal or external validity of the findings. The project did not include an analysis of factors that may threaten the internal or external validity of the findings. *This scoring element is not met.* • Scoring element 7.6 assessed if the project compared the results across multiple entities, such as different member subgroups, provider sites or MCOs. The project did not compare the results across multiple entities or subgroups and did not include an explanation or reasons for why data was not compared. *This scoring element is not met.* • Scoring element 8.1 assessed if the selected improvement strategy was evidence-based suggesting the test of change would likely to lead to the desired improvement in processes or outcomes. Evidence-based rationale specific to the interventions was not documented in the report. *This scoring element is not met.* • Scoring element 8.3 evaluated if a rapid-cycle PDSA approach was used to test the selected improvement strategies. The project included a PDSA approach to selecting the improvement strategies but did use this approach to test the improvement strategies after implementation. *This scoring element is not met.* • Scoring element 8.6 evaluated if the PIHP assessed the extent to which the improvement strategy was successful and identified potential follow-up activities. The project assessed the impact of improvement strategies on continuity of care outcomes; however, the project was not designed to improve continuity of care. *This scoring element is not met.* • Scoring element 9.1 assessed if the same methodology was used for baseline and repeat measurements. The aim statement did not provide a baseline measurement; therefore, the methodology could not be confirmed. *This scoring element is not met.* • Scoring element 9.2 evaluated if there was quantitative evidence of improvement in processes or outcomes of care. The initial and repeat measurement could not be compared because no baseline measurement was documented in the aim statement. *This scoring element is not met.* • Scoring element 9.3 assessed if the reported improvement in performance was likely to be a result of the selected improvement strategies. The initial and repeat measurement could not be confirmed as comparable; therefore, any improvement in performance cannot be verified. *This scoring element is not met.*
Recommendations
• Include at least one improvement strategy in the aim statement (2.1).

Non-Clinical
• Specify the beginning and end date of the time period for the PIP in the aim statement (2.3). • Ensure the aim statement is answerable by including all required elements (2.5). • Develop a measurable aim statement by including a baseline measure (2.6). • Ensure variables are adequate to answer the study question (5.1). • Ensure the performance measure assesses an important aspect of care that will make a difference to enrollees' health or functional status (5.2). • Ensure a process is in place for validating data collected from the electronic health record for accuracy and completeness (6.13). • Ensure the project includes baseline and repeat measurements of project outcomes to allow for statistical significance testing and accounting for factors that may influence the comparability or validity of the findings (7.2, 7.3, 7.4, 7.5). • Compare the results of the project across multiple entities or subgroups, or provide an explanation of why data was not compared (7.6). • Explain the rationale for the selected improvement strategies, including how the specific strategies are evidence-based (8.1). • Implement a rapid-cycle PDSA approach to test the improvement strategies after implementation (8.3). • Evaluate the effectiveness of improvement strategies on the project's aim statement and identify any follow-up activities based on the assessment results (8.6). • Ensure baseline and repeat measurement data is provided for all study questions (9.1, 9.2, 9.3).

Validation of Performance Improvement Projects - 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 35. 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, CY 2024, the actions taken to address the recommendations, and the degree to which the organizations addressed the recommendations.

Table 36. State-Level Progress

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
– Conduct analysis and interpretation of the PIP results using appropriate techniques and include an assessment of the extent to which any change in performance is statistically significant (7.3). – Present PIP results and findings in a concise and easily understood manner (7.7). – Utilize evidence-based interventions that are routinely assessed to lead to the desired improvement (8.1). – Assess the extent to which improvement strategies are successful (8.6). – Ensure projects conducted by the prepaid inpatient health plans use the same methodology for baseline and repeat measures (9.1). – Document if a significant change in performance relative to the baseline occurred (9.4).	– No progress on previous recommendations.	Low

The table below identifies the recommendations made by the EQRO in the prior review, CY 2024, the actions taken by the organizations to address the recommendations, and the degree to which each addressed the recommendations.

Table 37. MCO-Level Progress

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Anthem	– Ensure the goal for the measurement year is an	– The MCO documented analysis of the data according to the data analysis plan (7.1).	Low

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	improvement over the previous year's results (2.6). – Document analysis of the data according to the data analysis plan (7.1). – Document all stages of a continuous cycle of improvement in the PIP report (8.3). – Identify how the organization ensures strategies are culturally and linguistically appropriate in future project reports (8.4). – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care (Significant Improvement).	– The MCO identified how the organization ensured strategies for each project are culturally and linguistically appropriate (8.4).	
CCHP - C4K	– Ensure data analysis is conducted in accordance with the data analysis plan (7.1). – Include an analysis of the baseline and repeat measurements of the project outcomes. (7.2). – Include evidence of statistical analysis to assess differences between the initial and repeat measurements. (7.3). – Perform and document an analysis comparing the results to other entities or population subgroups (7.6). – Present results in a concise and easily understood manner (7.7). – Include lessons learned or opportunities for improvement	– The organization ensured data analysis was conducted in accordance with the data analysis plan (7.1). – The organization included an analysis of the baseline and repeat measurements of the project outcomes (7.2). – The organization included evidence of statistical analysis to assess differences between the initial and repeat measurements (7.3). – The organization performed and documented an analysis comparing the results to other entities or population subgroups (7.6). – The organization explained the rationale for the selected	Medium

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	based on the data analysis when the aim is not achieved (7.8). – Explain the rationale for the selected improvement strategies, including how the strategies are evidence-based (8.1). – Document a continuous cycle of improvement used to test a selected improvement strategy (8.3). – Develop a plan to address variables encountered during the project (8.5). – Using data analysis and interpretation, assess the extent to which the improvement strategies were successful (8.6). – Ensure the same methodology is used for baseline and repeat measurement (9.1). – Design a methodologically sound performance improvement project to ensure project results demonstrate an improvement from the baseline rate identified in the project's aim statement (9.2). – Develop and implement improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care (Significant Improvement).	improvement strategies, including how the strategies were evidence-based (8.1). – The organization developed a plan to address variables encountered during the project (8.5). – The organization completed data analysis to interpret results, assessed the extent to which the improvement strategies were successful, and identified potential follow-up activities (8.6). – The organization ensured the same methodology was used for baseline and repeat measurements. (9.1).	

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCHP	– Reduce the number of aim statements for a PIP to a maximum of one or two aim statements (Standard 2). – Ensure the aim statement clearly specifies the improvement strategies for the project (2.1). – Include all required criteria in the aim statement, ensuring it is answerable (2.5). – Explain the rationale for the selected improvement strategies, including how the strategies are evidence-based (8.1). – Continue to design a methodologically sound performance improvement project to ensure results demonstrate an improvement from the baseline rate identified in the project's aim statement (Significant Improvement).	– CCHP reduced the number of aim statements for each project to two aim statements (Standard 2). – Improvement strategies were specified for each aim statement (2.1). – CCHP explained the rationale for the selected improvement strategies, including how the strategies were evidence-based (8.1).	Medium
DHP	– Identify the year in which each PDSA cycle is completed in future project reports (8.3). – Assess the success of each individual improvement strategy and document the assessment in future project reports (8.6). – Ensure sustained improvement is demonstrated through repeated measurements over time for continuing projects (9.5).	– DHP identified the year in which each PDSA cycle was completed and documented each step (8.3). DHP assessed the success of each individual improvement strategy and documented the assessment in project reports (8.6).	Medium

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care (Significant Improvement).		
GHC-EC	– Conduct statistical testing analysis for all PIPs and aim statements in future project reports (7.3). – Clearly identify the baseline rate and maintain the rate when analyzing baseline and repeat measurements (7.7). – Document all steps of the Plan-Do-Study-Act cycle in future project reports (8.3). – Focus efforts to achieve improvement in all projects (9.2). – Ensure sustained improvement is demonstrated through repeated measurements over time for all continuing projects (9.5).	– GHC-EC conducted statistical testing analysis for all PIPs and aim statements (7.3). – GHC-EC clearly identified the baseline rate and maintained the rate when analyzing baseline and repeat measurements (7.7).	Low
GHC-SCW	– Ensure project results are compared across other entities, such as different organizations or sub-groups (7.6). – Ensure final project results are concise and easily understood (7.7). – Ensure improvement strategies are evidence based (8.1). – Utilize and document a Plan-Do-Study-Act approach to test the selected improvement strategies (8.3).	– GHC-SCW ensured project results were compared across other entities, such as different organizations or subgroups (7.6). – GHC-SCW ensured final project results were concise and easily understood (7.7).	Low

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Focus efforts on improving results to gain quantitative evidence of improvement through repeated measurements each year of a continuing project (9.5).		
*i*Care	– Clearly define the inclusion and exclusion criteria for the study population to ensure the data collection approach captures all members to whom the aim statement applies (3.1). – Ensure variables are adequate to answer the identified project question (5.1). – Include statistical analysis for all aims in future project reports (7.3). – Present findings in a concise and easily understood manner in future project reports (7.7). – Document potential follow-up activities in future project reports (8.6). – Design a methodologically sound performance improvement project to demonstrate improvement from baseline to remeasurement (9.2). – Enact selected improvement strategies with a statistically significant portion of the study population to achieve the desired improvement in outcomes of care (9.3). – Ensure sustained improvement is demonstrated through	– *i*Care defined the inclusion and exclusion criteria for the study population to ensure the data collection approached captured all members to whom the aim statements applied (3.1). – *i*Care ensured variables were adequate to answer the identified project question (5.1). – *i*Care presented findings in a concise and easily understood manner (7.7).	Low

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	repeated measurements over time for continuing projects (9.5). – Implement improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care (9.5). – Implement an intervention that is likely to result in performance improvement (Significant Improvement).		
MCHP	– Clearly specify the time period for the project in the aim statement (2.3). – Combine all elements of the aim statement into one brief statement to ensure the aim statement is concise (2.4). – Ensure aim statements are answerable by including all required elements (2.5). – Clearly define the project population in terms of the identified PIP aim statement (3.1). – Ensure variables are adequate to answer the study question (5.1). – Analyze data according to the data analysis plan or explain any deviation from the plan when warranted (7.1). – Include an analysis of the baseline and repeat measures identified according to the project aim statement (7.2).	– MCHP specified the time period for the project in all aim statements (2.3). – All aim statements were concise (2.4). – MCHP analyzed the data according to the data analysis plan and explained any deviation from the plan when warranted (7.1). – The reports included an analysis of the baseline and repeat measures identified according to the project aim statements (7.2). – MCHP developed methodologically sound projects to demonstrate quantitative evidence of improvements (9.2). – Improvement strategies were used that were likely to lead to the desired improvement in processes or outcomes of care (Significant Improvement). – Baseline and repeat measurements were reported	Low

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Conduct and include statistical analysis when results improve or decline in future project reports (7.3). – Ensure project results are compared across other entities, such as different organizations or sub-groups (7.6). – Ensure PIP findings are presented in an easily understood manner (7.7). – Assess and describe the effectiveness of each improvement strategy in future reports (8.6). – Continue to develop methodologically sound projects to demonstrate quantitative evidence of improvements (9.2). – Include statistical evidence that any observed improvement is the result of the interventions (9.4). – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care (Significant Improvement). – Report the baseline and repeat measurements according to the aim statements in future projects (Significant Improvement).	according to the aim statements (Significant Improvement).	
MHS	– Ensure aim statements are concise (2.4). – Establish a goal that is an improvement over the rate	– The organization ensured aim statements were concise (2.4). – The MCO established goals that demonstrated improvement over	Medium

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	obtained during the previous measurement year (2.6). – Ensure the project's results and findings are presented in a concise and easily understood manner (7.7). – Demonstrate sustained improvement through repeated measurements over time for continuing projects (9.5). – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care (Significant Improvement).	the rate obtained during the previous measurement year (2.6). – The project's results and findings were presented in a concise and easily understood manner (7.7).	
MHWI	– Ensure the aim statement clearly specifies the improvement strategy (2.1). – Clearly define the population in the aim statement (2.2). – Identify the beginning and end date of the project in the aim statement (2.3). – Ensure aim statement includes all required criteria (2.5). – Ensure the aim statement is measurable (2.6). – Include an analysis of the baseline and repeat measures identified according to the project aim statement (7.2). – Conduct statistical testing analysis for all aim statements in future project reports (7.3).	– MHWI clearly specified improvement strategies in the aim statements (2.1). – MHWI identified the beginning and end date of the project in the aim statement (2.3). – MHWI developed measurable aim statements (2.6). – MHWI included analysis of baseline and repeat measures identified in the project aim statements (7.2). – MHWI conducted statistical testing analysis for all aim statements (7.3).	Low

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Ensure that selected improvement strategies utilized are evidence-based (8.1). – Develop methodologically sound projects to demonstrate quantitative evidence of improvement (9.2). – Develop and implement improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care. (Significant Improvement).		
NHP	– Ensure aim statements are concise (2.4). – Establish a goal that is an improvement over the rate obtained during the previous measurement year (2.6). – Ensure the project's results and findings are presented in a concise and easily understood manner (7.7). – Ensure sustained improvement is demonstrated through repeated measurements over time for continuing projects (9.5). – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care (Significant Improvement).	– The organization ensured aim statements were concise (2.4). – The MCO established goals that were an improvement over the rate obtained during the previous measurement year (2.6).	Low

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Quartz	– Ensure the aim statement clearly specifies the population for the project (2.2). – Identify the population within the aim statement to guarantee the aim statement is answerable (2.5). – Identify a numeric measurement goal of improvement to guarantee the aim statement is measurable (2.6). – Ensure the data collection approach captures all enrollees to whom the project question applies when the entire population is included (3.2). – Update the aim statement and other relevant standard narrative when a new measure is required to conduct the project (5.1). – Include a strategy to ensure interrater reliability for manual data entry (5.9). – Ensure an interrater reliability process is in place for medical record review (6.15). – Document guidelines for obtaining and recording data from medical record review (6.16). – Generate a baseline rate specific to the organization to ensure statistical testing can be conducted to determine the differences between initial and repeat measures (7.3).	– Quartz clearly specified the population for the project in the aim statements (2.2). – Quartz identified a numeric measurement goal of improvement to guarantee the aim statements were measurable (2.6). – Quartz ensured the data collection approach captured all enrollees to whom the project question applied (3.2). – Quartz ensured the variables were adequate to answer the PIP question (5.1). – Quartz included a strategy to ensure interrater reliability for manual data entry (5.9). – Quartz guaranteed an interrater reliability process was in place for medical record reviews (6.15). – Quartz documented guidelines for obtaining and recording data from medical record reviews (6.16). – Quartz generated an organization specific baseline rate to guarantee statistical testing could be conducted to determine differences between initial and repeat measures (7.3). – Quartz accounted for factors that could have influenced the comparability of initial and repeat measures (7.4). – Quartz compared project results across multiple entities or subgroups (7.6).	Medium

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Account for factors that may influence the comparability of initial and repeat measures (7.4). – Compare project results across multiple entities or subgroups (7.6). – Present project findings in a concise and easily understood manner (7.7). – Implement a strategy designed to account or adjust for any major confounding variables (8.5). – Ensure the same methodology is used for baseline and repeat measurements (9.1). – Continue to build methodologically sound performance improvement projects to ensure quantitative improvement is demonstrated from baseline to repeat rates (9.2). – Ensure project improvement is the result of the intervention (9.3). – Include statistical evidence that any observed improvement is the result of the intervention (9.4). – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care (Significant Improvement). – Generate a baseline specific to the organization to ensure	– Quartz implemented a strategy that was designed to account or adjust for any major confounding variables (8.5). – Quartz ensured the same methodology was used for baseline and repeat measurements (9.1). – Quartz ensured project improvement was the result of the selected interventions (9.3). – Quartz included statistical evidence that any observed improvement was the result of the intervention (9.4). – Quartz generated a baseline specific to the organization to ensure comparability between baseline and repeat measurements (Significant Improvement).	

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	comparability between baseline and repeat measurements (Significant Improvement).		
SHP	– Conduct a member needs analysis to prioritize and select a topic as an area for improvement for future projects (1.1). – Include the project's improvement strategy in future aim statements (2.1). – Clearly specify the time period for the project in the aim statement (2.3). – Ensure the aim statement is concise (2.4). – Ensure aim statements are answerable by including all required elements (2.5). – Detail the staff responsible for medical record data abstraction and their relevant qualifications (6.14). – Describe the interrater and intra-rater reliability process for staff conducting medical record chart review (6.15). – Ensure continuous cycles of improvement are detailed in the PIP report (8.3). – Assess and describe the effectiveness of each improvement strategy in future reports (8.6). – Continue to develop methodologically sound projects to demonstrate	– SHP conducted a member needs analysis to prioritize and select topics as an area for improvement (1.1). – SHP clearly specified the time period for the project in the aim statements (2.3). – SHP detailed the staff responsible for medical record data abstraction and their relevant qualifications (6.14). – SHP described the interrater and intra-rater reliability process for staff conducting medical record chart review (6.15). – SHP assessed and described the effectiveness of each improvement strategy (8.6). – SHP developed methodologically sound projects to demonstrate quantitative evidence of improvement (9.2). – SHP utilized improvement strategies that were likely to lead to the desired improvement in processes or outcomes of care (Significant Improvement).	Medium

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	quantitative evidence of improvement (9.2). – Focus efforts on improving results of repeat measurements each year of a continuing project (9.5). – Utilize improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care (Significant Improvement).		
UHC	– Continue to build methodologically sound performance improvement projects to demonstrate improvement from baseline to remeasurement (9.2). – Ensure sustained improvement is demonstrated through repeated measurements over time for continuing projects (9.5).	– No progress was identified.	Low
WM	– Clearly specify the beginning and end date of the time period for the PIP in each aim statement (2.3). – Ensure each aim statement is answerable by including accurate criteria for the aim (2.5). – Develop measurable aim statements by including a baseline measure for each aim (2.6). – Ensure analysis includes baseline and repeat measures for each aim statement (7.2).	– No progress was identified.	Low

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Develop methodologically sound projects to demonstrate quantitative evidence of improvement (9.2). – Develop and implement improvement strategies that are likely to lead to the desired improvement in processes or outcomes of care (Significant Improvement).		

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. Details on the methodology MetaStar used to validate performance measures are provided in Appendix 1.

Quality indicators for MCOs for CY 2024, reported in CY 2025, are presented in the *Wisconsin Department of Health Services (DHS) Division of Medicaid Services (DMS) HMO Quality Guide for Measurement Year (MY) 2023*. This guide includes data for the BC+ and SSI programs. Quality indicators for the FCMH program are reported separately in the DHS DMS Foster Care Medical Home Quality Guide for MY 2023.

In addition to meeting federal performance measurement requirements set by CMS, DHS uses this data to establish and monitor quality benchmarks for each MCO. As part of its performance improvement strategy, DHS has implemented Pay-for-Performance incentives for BC+ and SSI MCOs to encourage improvement in priority HEDIS® measures. This strategy is a key component of the Medicaid Managed Care Strategy and is closely linked to the mandatory EQR Protocol 2: Validation of Performance Measures.

According to 42 CFR § 438.360, states may use results from private accreditation reviews to avoid duplication, provided the standards are comparable to those outlined in the EQR protocols and 42 CFR § 438.358. The performance measures identified by DHS are NCQA HEDIS® measures, standardized metrics developed by NCQA to objectively assess and compare health plan quality. These measures are validated by a certified NCQA HEDIS® auditor. While MetaStar does not conduct formal validation, it performs an analysis of the reported results to support quality oversight and improvement efforts.

To assess the effectiveness and quality of care provided through BC+, the following performance measures are utilized across key health domains:

Children's Health – Primary Care Access and Preventative Care

- Childhood Immunization Status - Combo 3 (CIS)
- Immunizations for Adolescents - Combo 2 (IMA)
- Lead Screening in Children (LSC)
- Child and Adolescent Well-Care Visits (Total) (WCV)

Maternal Health

- Prenatal and Postpartum Care - Timeliness of Prenatal Care (PPC)
- Prenatal and Postpartum Care - Postpartum Care (PPC)

Disease Management – Chronic Conditions

- Asthma Medication Ratio (Total) (AMR)
- Glycemic Status Assessment for Patients with Diabetes <8.0% (GSD) – formerly Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Controlling Blood Pressure (CBP)

Disease Management – Behavioral Health

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

To assess the effectiveness and quality of care provided through SSI, the following performance measures are utilized across key health domains:

Chronic Conditions

- Asthma Medication Ratio (Total) (AMR)
- Glycemic Status Assessment for Patients with Diabetes <8.0% (GSD) – formerly Hemoglobin A1c Control for Patients with Diabetes (HBD)

Behavioral Health

- Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total (FUH)
- Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total) (FUM)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Preventative Health

- Breast Cancer Screening (BCS-E)
- Cervical Cancer Screening (CCS)

To assess the effectiveness and quality of care provided through FCMH, the following performance measures are utilized:

- Childhood Immunization Status – Combo 3 (CIS)
- Immunizations for Adolescents – Combo 2 (IMA)

- Lead Screening in Children (LSC)
- Outpatient Mental Health Follow-Up 7 Days After Hospitalization for Mental Illness (Ages 6 - 17) (FUH)
- Outpatient Mental Health Follow-Up 30 Days After Hospitalization for Mental Illness (Ages 6 – 17) (FUH)
- Outpatient Mental Health Follow-Up 7 Days After ED Visit for Mental Illness (Ages 6 - 17) (FUM)
- Outpatient Mental Health Follow-Up 30 Days After ED Visit for Mental Illness (Ages 6 - 17) (FUM)

Validation of Performance Measures - Results

This report addresses the compliance with PMV requirements for the review periods identified in the tables above, with evaluation conducted in CY 2025. The state rates for all measures were calculated using the guidance found with the *Centers for Medicare & Medicaid Services – Medicaid & CHIP Health Care Quality Measures Technical Assistance Resource* for calculating state-level rates using data from multiple reporting units. Methods to calculate rates for administrative, hybrid, and a combination of the two were utilized and completed by DHS.

HEDIS® Measurement Year (MY) 2024 data, reported in CY 2025, was used for analysis. HEDIS® rates are reported by Measurement Year (MY), which aligns with the calendar year. For this activity, MY will be used when discussing HEDIS® rates to align with the technical specifications. MY 2024 HEDIS® rates were reported in CY 2025 and were reviewed and analyzed for this activity.

MetaStar compared the State's performance on national HEDIS® measures with national benchmarks published annually by NCQA in the *Quality Compass®*[3] report with the permission of NCQA. These benchmarks represent performance of NCQA-accredited Medicaid managed care plans and Medicaid managed care plans that are either required to report HEDIS® measures by the state agency responsible for monitoring managed Medicaid performance or opt to publicly report their HEDIS® rates. The HEDIS® measures reported to NCQA vary by plan. These national benchmarks reflect the average of the plans that reported the benchmark and are not a true national average of all Medicaid managed care plans. Also, note these plans represent states with and without Medicaid expansion coverage.

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

Rates are expressed as percentages, which represent the proportion of eligible members who received the recommended service or met the measure criteria. In contrast, national benchmarks are expressed as percentiles, which indicate how a health plan's performance compares to other reporting plans nationwide. Percentiles do not reflect the actual percentage of compliance but rather the relative ranking among peers.

- Percentages measure absolute performance (how many members received the service).
- Percentiles measure relative performance (how the plan compares to others).

These benchmarks help identify areas for improvement. MCOs below the 50th percentile show significant room for growth, while those above the 75th percentile may prioritize other measures.

Due to licensing restrictions with NCQA, only a limited number of benchmarks can be published each year. For this analysis, the selected benchmarks are the national 50th percentile and 75th percentile. These benchmarks are used to categorize each MCO's performance into three levels identified in the table below.

Table 38. PMV Ratings

National Benchmark	Result	Meaning
Above 75th Percentile	Strength	The MCOs are performing better than most others nationally.
75th - 50th Percentile	Compliant	The MCOs meet acceptable standards but have room for improvement.
Below 50th Percentile	Opportunity	The MCOs are underperforming compared to peers and may need targeted support.

This rating system helps identify where MCOs excel, meet expectations, or require improvement. It also supports prioritizing quality improvement efforts based on comparative performance. See Appendix 1 for more information about the scoring methodology.

Assessment of each MCO's information system is a required component of performance measure validation and other federally mandated review activities. For the current review cycle, the information systems of each MCO were evaluated through their accreditation process, specifically by reviewing the FARs. MetaStar determined that the accreditation review conducted by NCQA sufficiently addresses all requirements outlined in Appendix A of the CMS External Quality Review Protocol.

BadgerCare Plus Results

Table 39. BC+ Performance Measures

Performance Measure	MY 2023 State Rate	MY 2024 State Rate	50th Percentile	75th Percentile	Results
Childhood Immunization Status - Combo 3 (CIS)	62.0%	65.0%	67.4%	72.1%	Opportunity
Immunizations for Adolescents - Combo 2 (IMA)	36.0%	36.0%	36.5%	43.6%	Opportunity
Lead Screening in Children (LSC)	67.9%	75.1%	70.0%	76.3%	Compliant
Child and Adolescent Well-Care Visits (Total) (WCV)	50.2%	54.6%	55.4%	61.5%	Opportunity
Prenatal and Postpartum Care - Timeliness of Prenatal Care (PPC)	87.8%	88.5%	86.4%	89.8%	Compliant
Prenatal and Postpartum Care - Postpartum Care (PPC)	82.1%	84.0%	82.5%	85.2%	Compliant
Asthma Medication Ratio (Total) (AMR)	65.7%	61.3%	63.7%	70.4%	Opportunity
Glycemic Status Assessment for Patients with Diabetes <8.0% (GSD)*	56.6%	62.1%	60.6%	64.7%	Compliant
Controlling Blood Pressure (CBP)	66.7%	70.2%	67.9%	71.3%	Compliant
Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total (FUH)	62.9%	63.6%	62.1%	70.6%	Compliant

**NCQA updated this measure MY 2024. The rate is still comparable to the previous HBD measure, though a 'allow trending with caution' has been issued.*

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

Promoting child health is fundamental to supporting a child's overall well-being and development. Preventive care and screening measures are critical indicators of whether enrollees receive timely and appropriate services to help avoid chronic conditions and acute health issues. These measures serve as reflections of both access to care and the quality of services provided. The table below presents the performance rates achieved by each MCO for the measures within this domain.

Table 40. BC+ Children's Health Performance Measures – MCO Comparison

MCO	CIS – Combo 3	IMA – Combo 2	LSC	WCV - Total
Anthem	67.4%	36.5%	75.2%	55.7%
CCHP	61.5%	38.9%	78.5%	55.8%

MCO	CIS – Combo 3	IMA – Combo 2	LSC	WCV - Total
DHP	70.1%	43.3%	72.5%	55.8%
GHC-EC	58.6%	37.5%	68.9%	52.3%
GHC-SCW	55.5%	36.6%	64.4%	41.3%
*i*Care	65.5%	33.4%	77.0%	49.3%
MCHP	60.7%	37.1%	61.2%	49.2%
MHS	66.7%	31.6%	80.0%	51.0%
MHWI	58.7%	36.0%	74.9%	55.4%
NHP	64.7%	29.2%	76.9%	51.8%
Quartz	59.4%	38.9%	68.4%	49.6%
SHP	63.5%	30.4%	69.7%	55.2%
UHC	68.9%	34.1%	76.7%	56.1%

The graphs below illustrate each performance measure as reported by individual MCOs, alongside the statewide aggregate rate and national benchmarks at the 50th and 75th percentiles. This visual comparison highlights how each MCO performs relative to peers within the state and against national standards.

Chart 4. BC+ Childhood Immunization Status (Combo 3) (CIS)

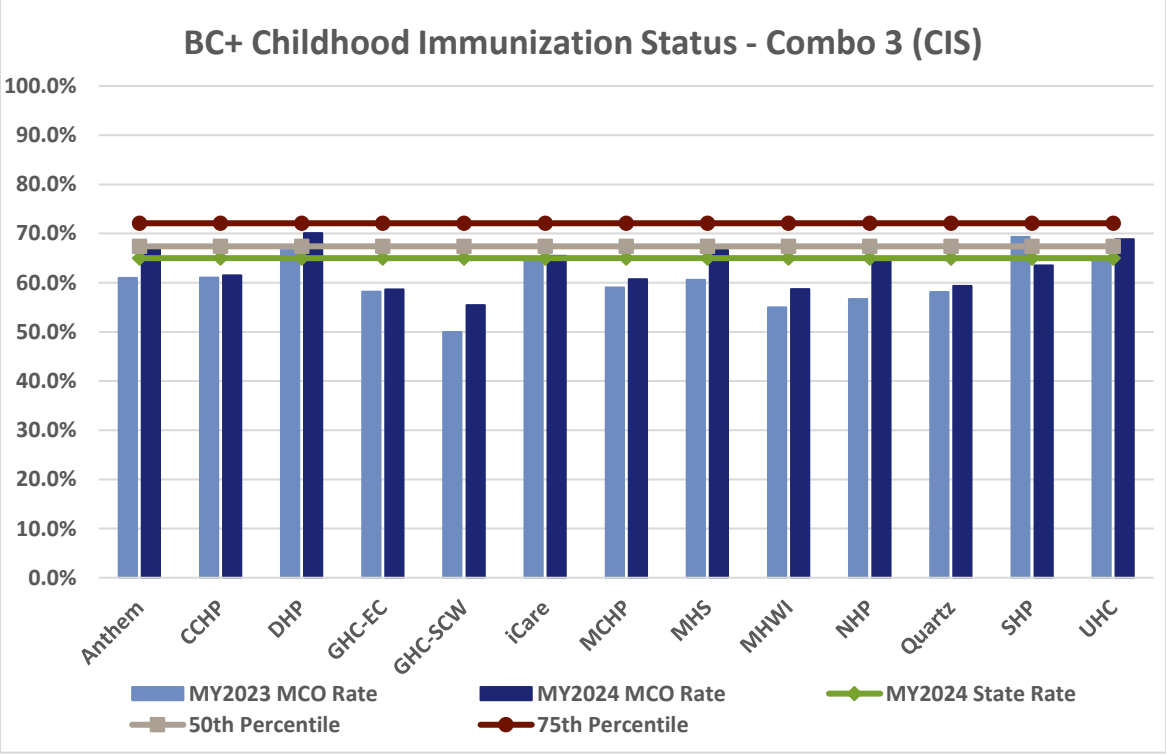


Chart 5. BC+ Immunizations for Adolescents (Combo 2) (IMA)

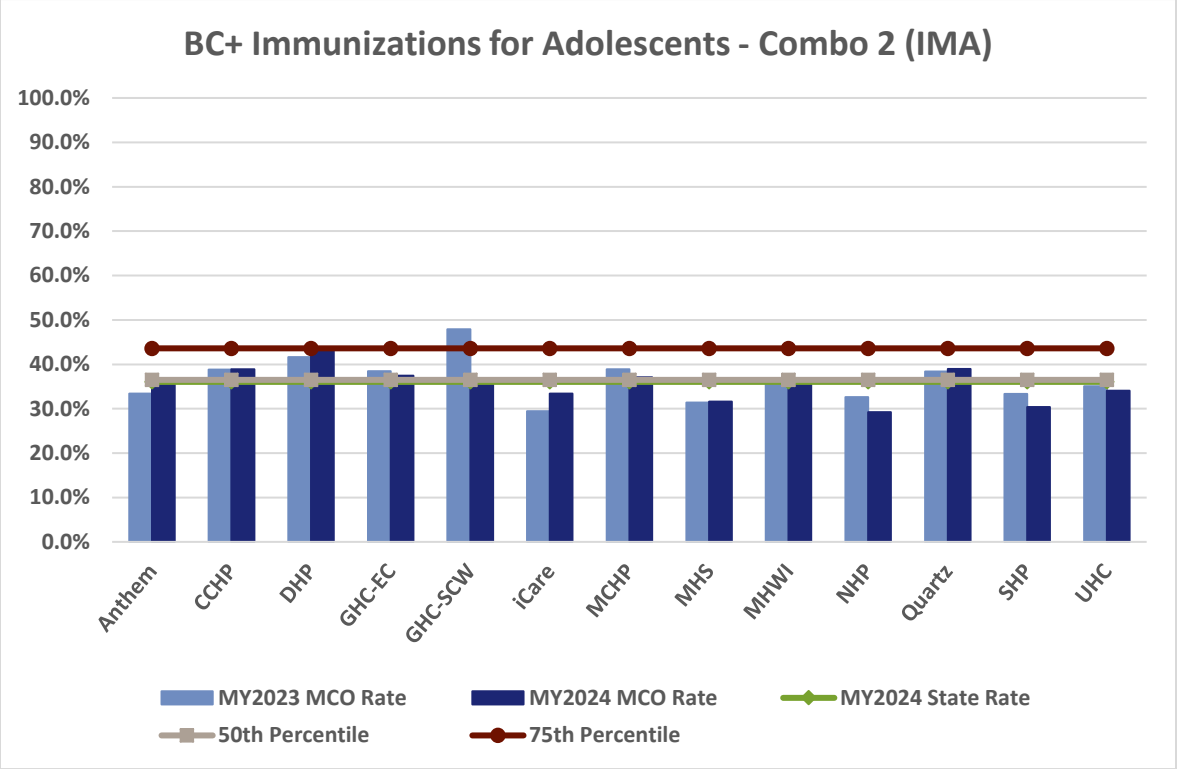


Chart 6. BC+ Lead Screening in Children (LSC)

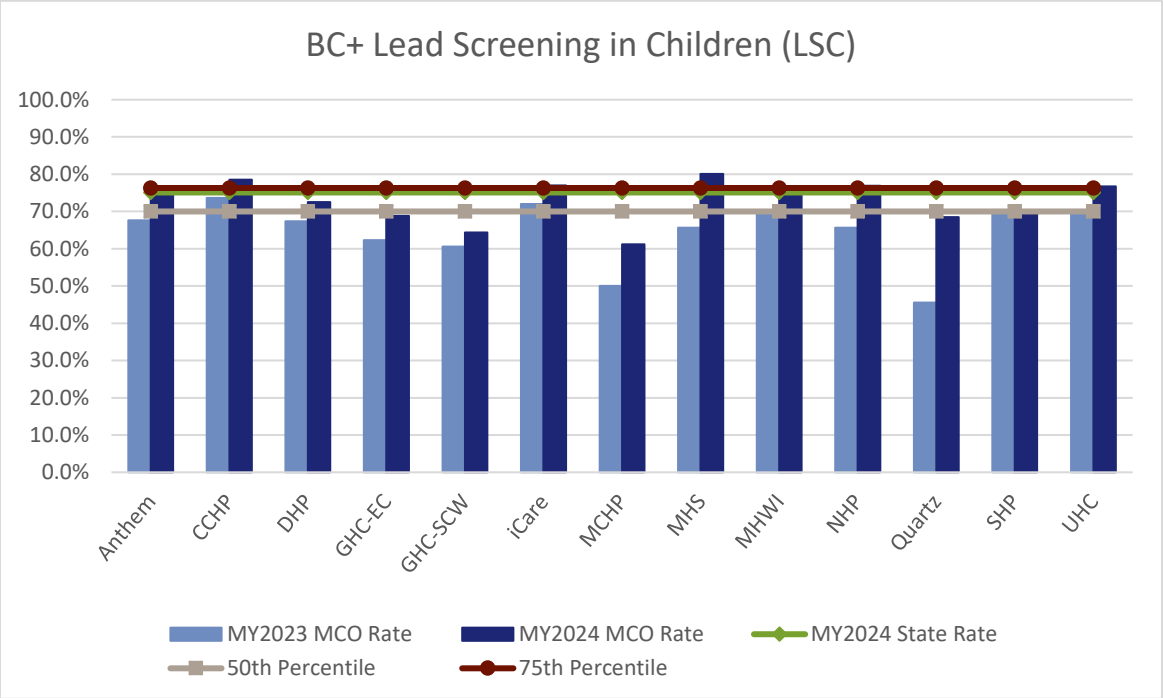
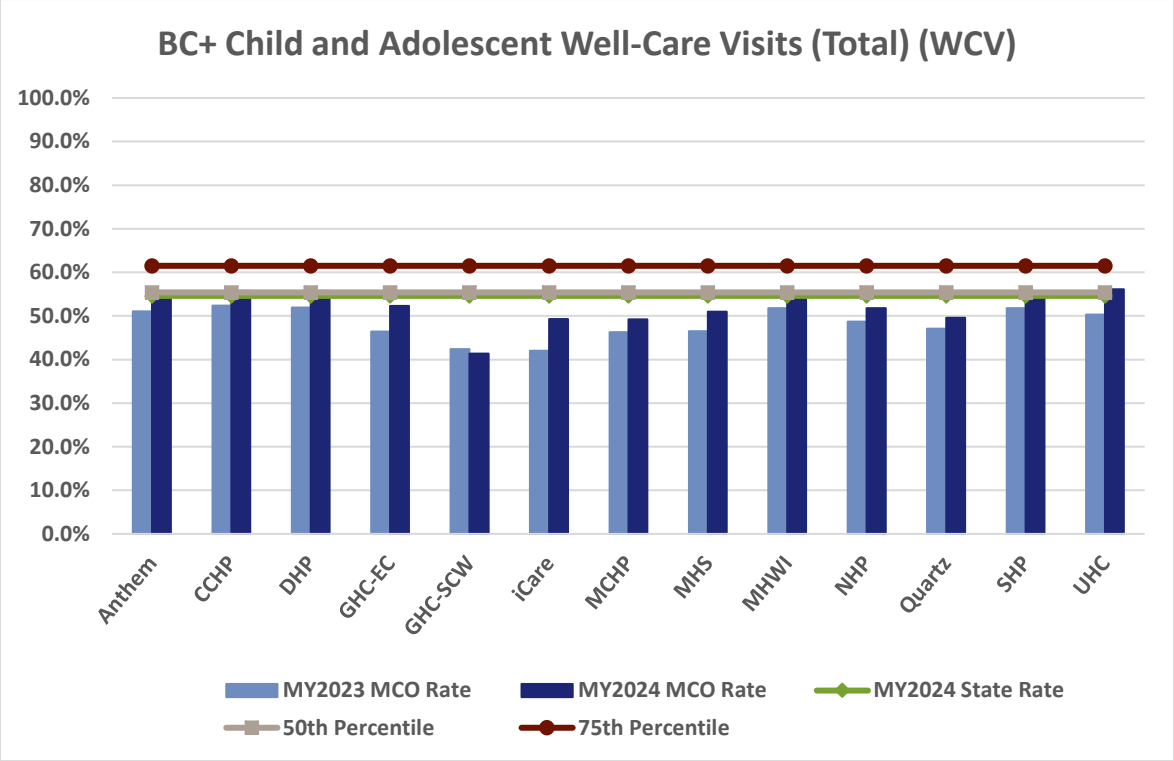


Chart 7. BC+ Child and Adolescent Well-Care Visits (Total) (WCV)



BC+ Maternal Health

Maternal health includes measures related to adequate prenatal and postpartum care, which are essential for positive pregnancy outcomes. These measures reflect access and quality. The table below presents the performance rates achieved by each MCO for the measures within this domain.

Table 41. BC+ Maternal Health Performance Measures – MCO Comparison

MCO	PPC - Prenatal	PPC - Postpartum
Anthem	84.9%	78.3%
CCHP	89.5%	86.6%
DHP	90.8%	83.2%
GHC-EC	91.2%	91.0%
GHC-SCW	80.2%	77.0%
*i*Care	83.0%	82.0%
MCHP	90.0%	85.4%
MHS	88.8%	82.7%
MHWI	84.7%	79.1%
NHP	88.3%	82.5%
Quartz	86.4%	82.0%

MCO	PPC - Prenatal	PPC - Postpartum
SHP	87.3%	83.1%
UHC	92.2%	88.3%

The following graphs illustrate each performance measure as reported by individual MCOs, alongside the statewide aggregate rate and national benchmarks at the 50th and 75th percentiles. This visual comparison highlights how each MCO performs relative to peers within the state and against national standards.

Chart 8. BC+ Timeliness of Prenatal Care (PPC)

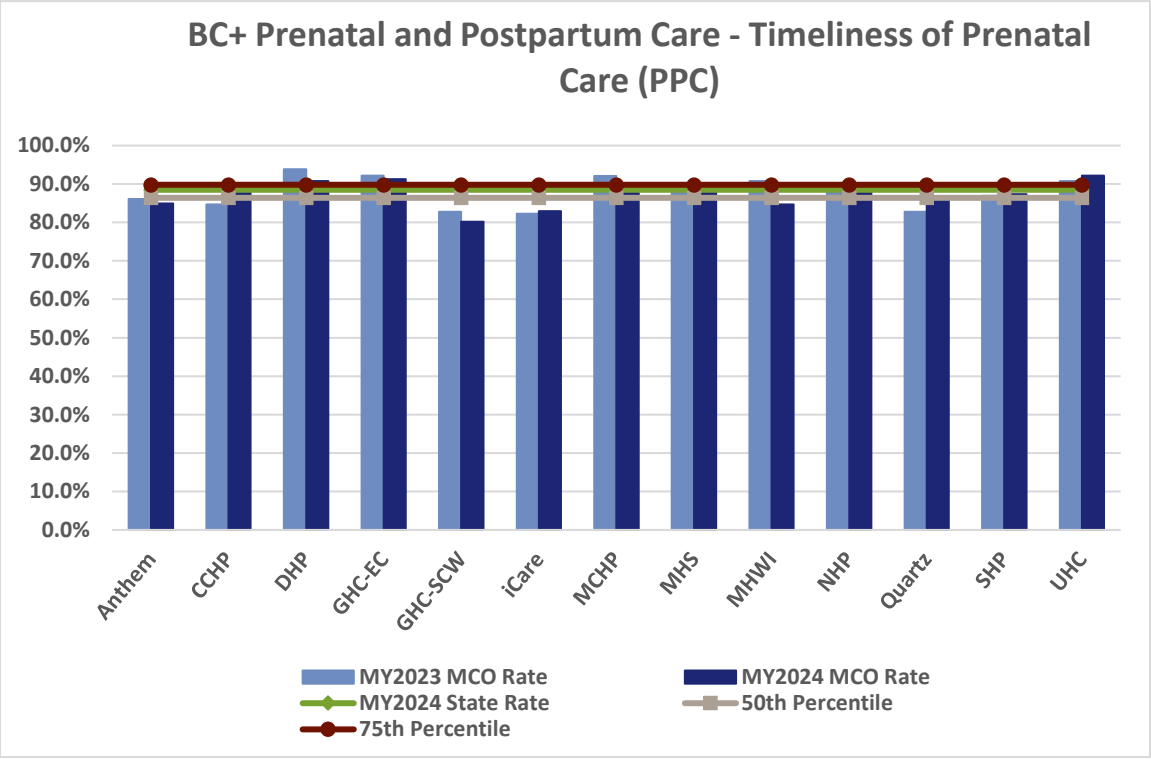
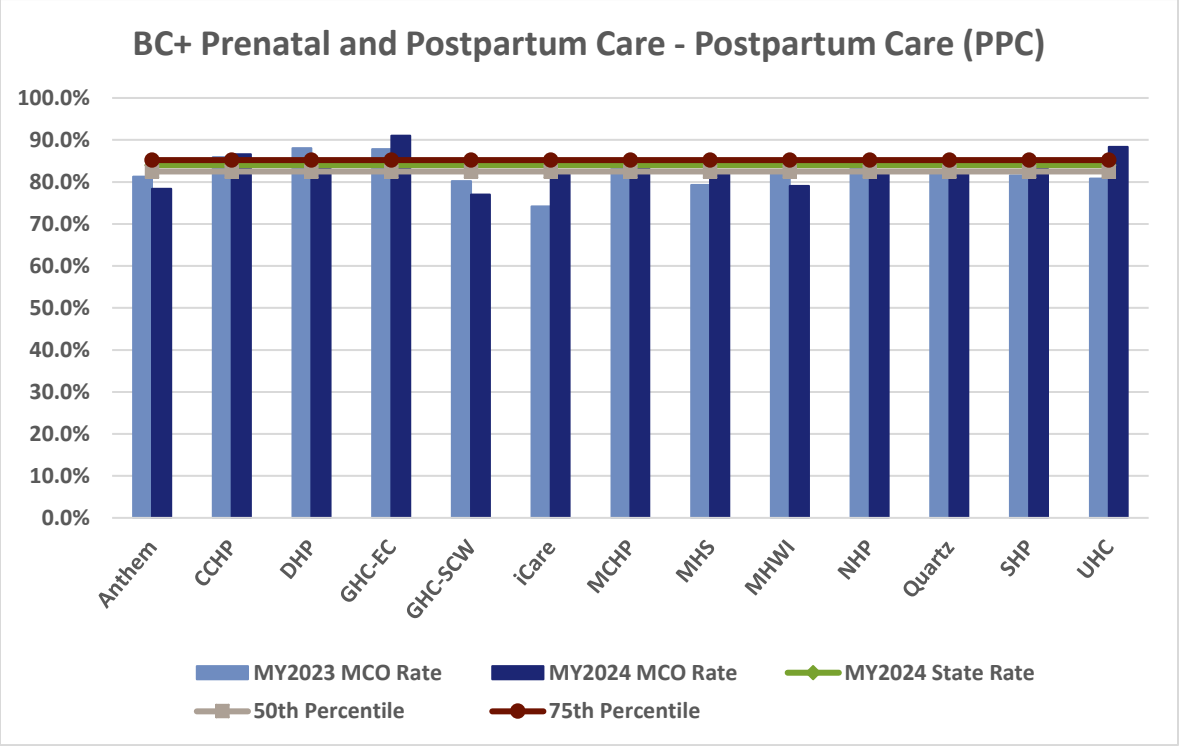


Chart 9. BC+ Postpartum Care (PPC)



BC+ Disease Management – Chronic Conditions

Disease management measures relate to whether enrollees with chronic conditions receive adequate outpatient management services to prevent worsening of chronic conditions and more costly inpatient and emergency department services. These measures reflect access and quality. The table below presents the performance rates achieved by each MCO for the measures within this domain.

Table 42. BC+ Disease Management - Chronic Conditions Performance Measures – MCO Comparison

MCO	AMR (Total)	GSD <8.0%	CBP
Anthem	62.0%	62.0%	69.3%
CCHP	61.1%	61.1%	68.1%
DHP	49.5%	58.0%	70.2%
GHC-EC	67.1%	67.4%	69.8%
GHC-SCW	58.4%	69.1%	60.1%
*i*Care	58.3%	55.5%	66.7%
MCHP	52.1%	51.4%	72.0%
MHS	63.5%	57.9%	68.4%

MCO	AMR (Total)	GSD <8.0%	CBP
MHWI	57.8%	57.9%	67.9%
NHP	63.5%	62.8%	72.3%
Quartz	61.1%	69.2%	63.6%
SHP	66.2%	67.8%	76.9%
UHC	62.6%	62.8%	72.3%

The following graphs illustrate each performance measure as reported by individual MCOs, alongside the statewide aggregate rate and national benchmarks at the 50th and 75th percentiles. This visual comparison highlights how each MCO performs relative to peers within the state and against national standards.

Chart 11. BC+ Asthma Medication Ratio (Total) (AMR)

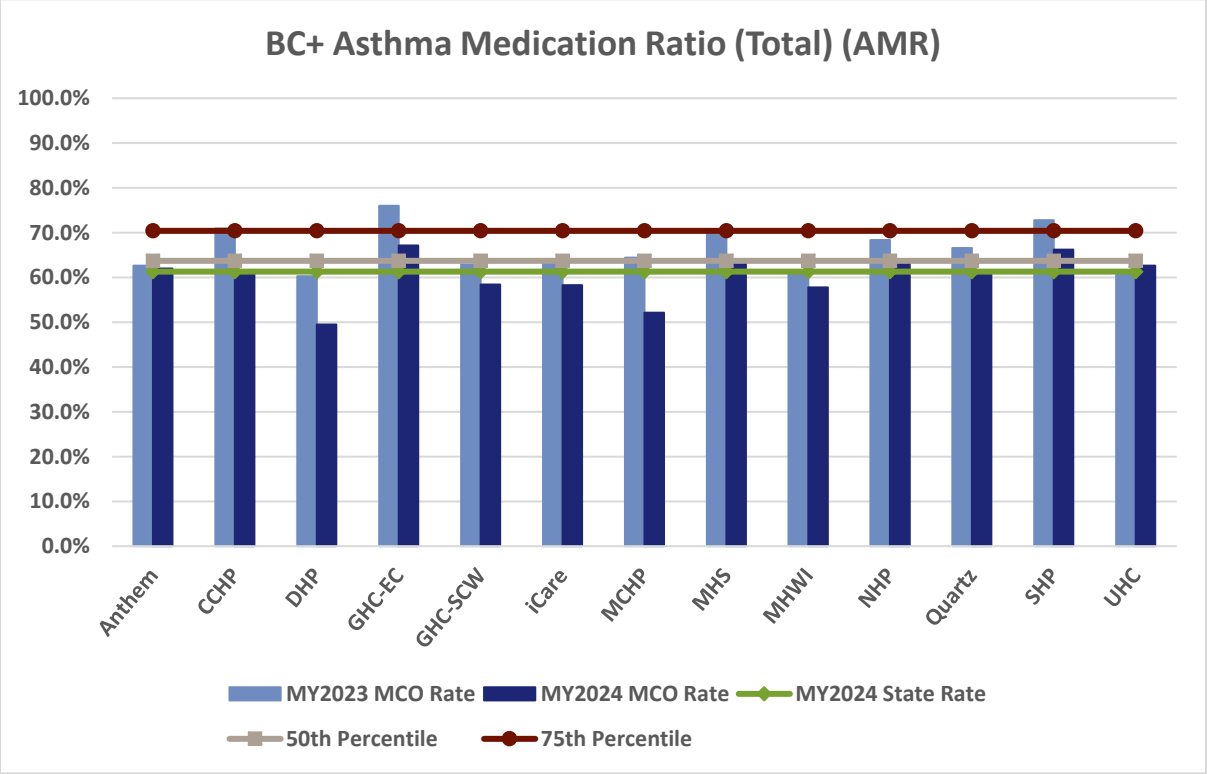


Chart 12. BC+ Glycemic Status Assessment for Patients with Diabetes <8.0% (GSD) – formerly Hemoglobin A1c Control for Patients with Diabetes (HBD)

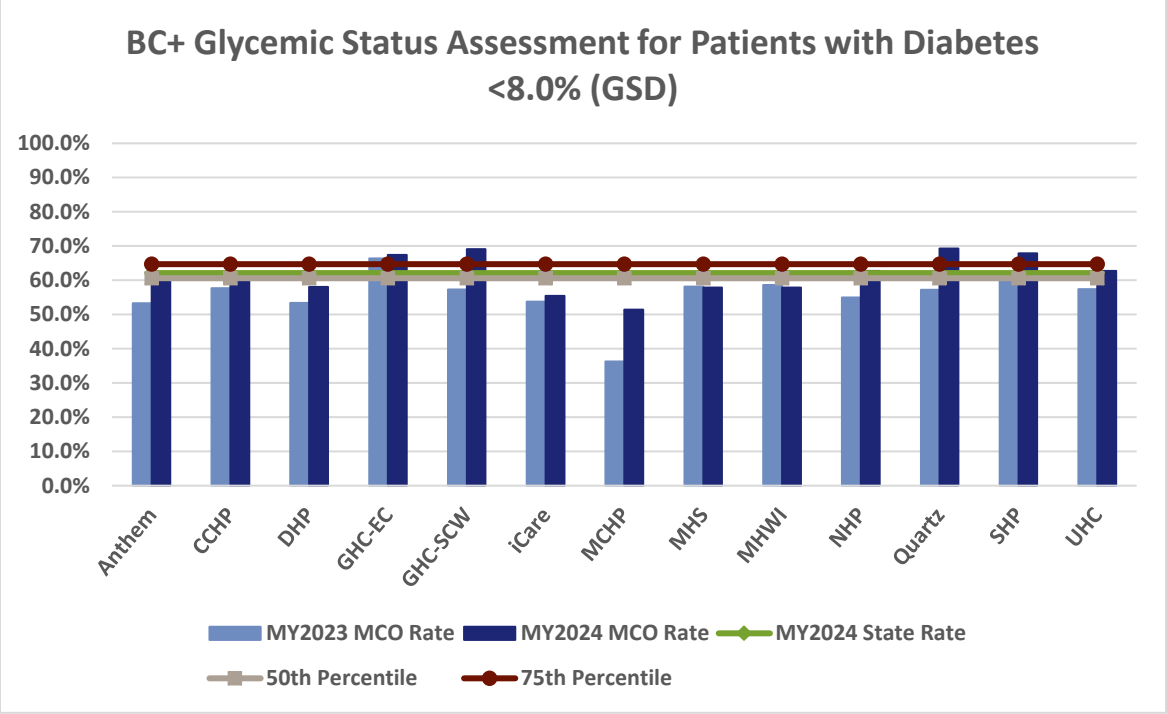
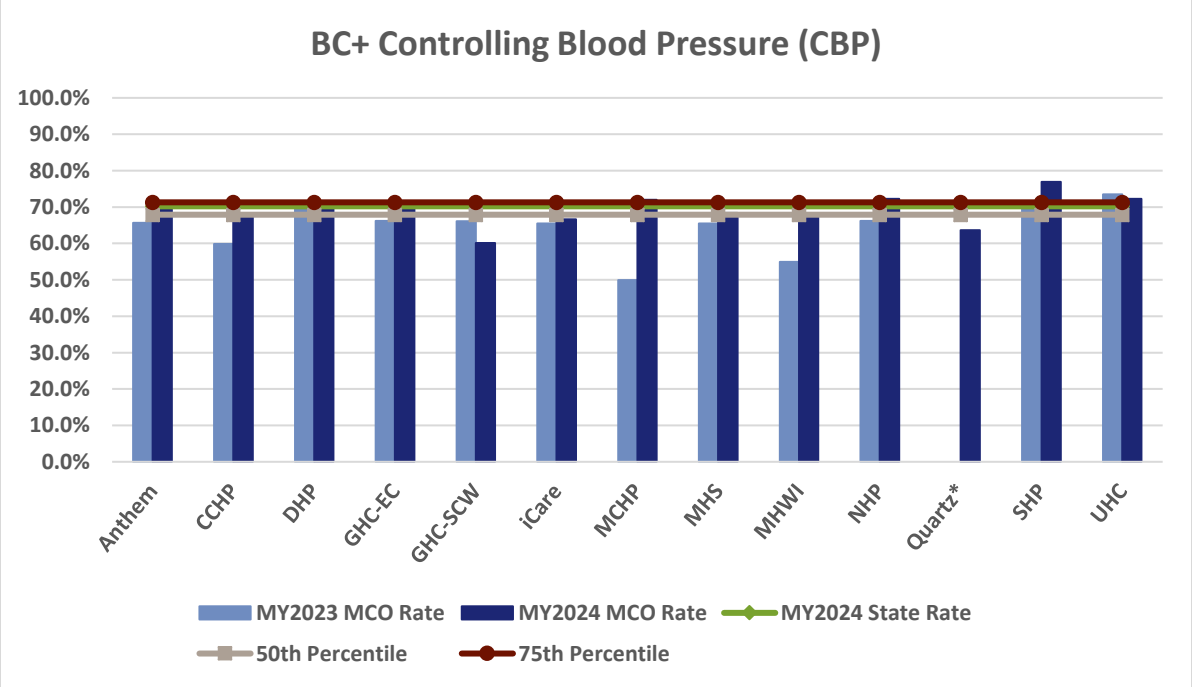


Chart 13. BC+ Controlling Blood Pressure (CBP)



**Denominator <30, not reportable*

BC+ Disease Management – Behavioral Health

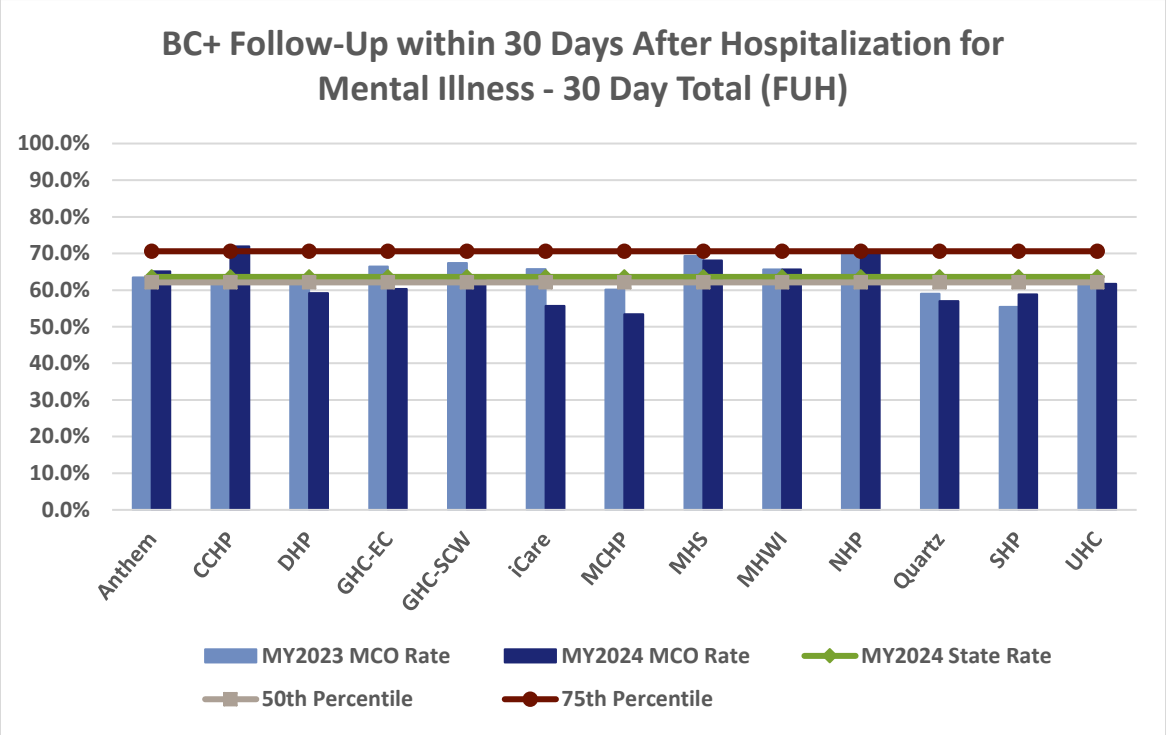
Improving the management of behavioral health involves comprehensive strategies to enhance care, support, and outcomes for individuals facing mental health conditions. The measure for timely follow-up after hospitalization for mental illness ensures that enrollees who have been hospitalized due to a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

Table 43. BC+ Disease Management - Chronic Conditions Performance Measures – MCO Comparison

MCO	FUH – 30 Day Total
Anthem	65.1%
CCHP	71.9%
DHP	59.1%
GHC-EC	60.3%
GHC-SCW	63.6%
*i*Care	55.7%
MCHP	53.4%
MHS	68.1%
MHWI	65.6%
NHP	70.2%
Quartz	56.9%
SHP	58.8%
UHC	61.7%

The following graph illustrates the performance measure as reported by individual MCOs, alongside the statewide aggregate rate and national benchmark at the 50th and 75th percentiles. This visual comparison highlights how each MCO performs relative to peers within the state and against national standards.

Chart 14. BC+ Follow-Up After Hospitalization for Mental Illness - 30 Days (Total) (FUH)



Supplemental Security Results

Table 44. SSI Performance Measures

Performance Measure	MY 2023 State Rate	MY 2024 State Rate	50th Percentile	75th Percentile	Results
Asthma Medication Ratio (Total) (AMR)	62.8%	57.2%	63.7%	70.4%	Opportunity
Glycemic Status Assessment for Patients with Diabetes <8.0% (GSD)*	60.4%	62.8%	60.6%	64.7%	Compliant
Follow-Up After Hospitalization for Mental Illness - 30 Days (Total) (FUH)	61.3%	62.9%	62.1%	70.6%	Compliant
Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total) (FUM)	54.0%	57.0%	57.1%	64.9%	Opportunity
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	80.4%	78.6%	82.8%	85.1%	Opportunity
Breast Cancer Screening (BCS-E)	53.6%	56.4%	55.9%	61.4%	Compliant

Performance Measure	MY 2023 State Rate	MY 2024 State Rate	50th Percentile	75th Percentile	Results
Cervical Cancer Screening (CCS)	58.0%	59.2%	58.2%	64.1%	Compliant

**NCQA updated this measure MY 2024. The rate is still comparable to the previous HBD measure, though a 'allow trending with caution' has been issued.*

SSI Chronic Conditions

Chronic disease management measures relate to whether enrollees with chronic conditions receive adequate outpatient management services to prevent worsening of chronic conditions and more costly inpatient and emergency department services. These measures reflect access and quality. The measure reflects access and quality. The table below presents the performance rates achieved by each MCO for the measures within this domain.

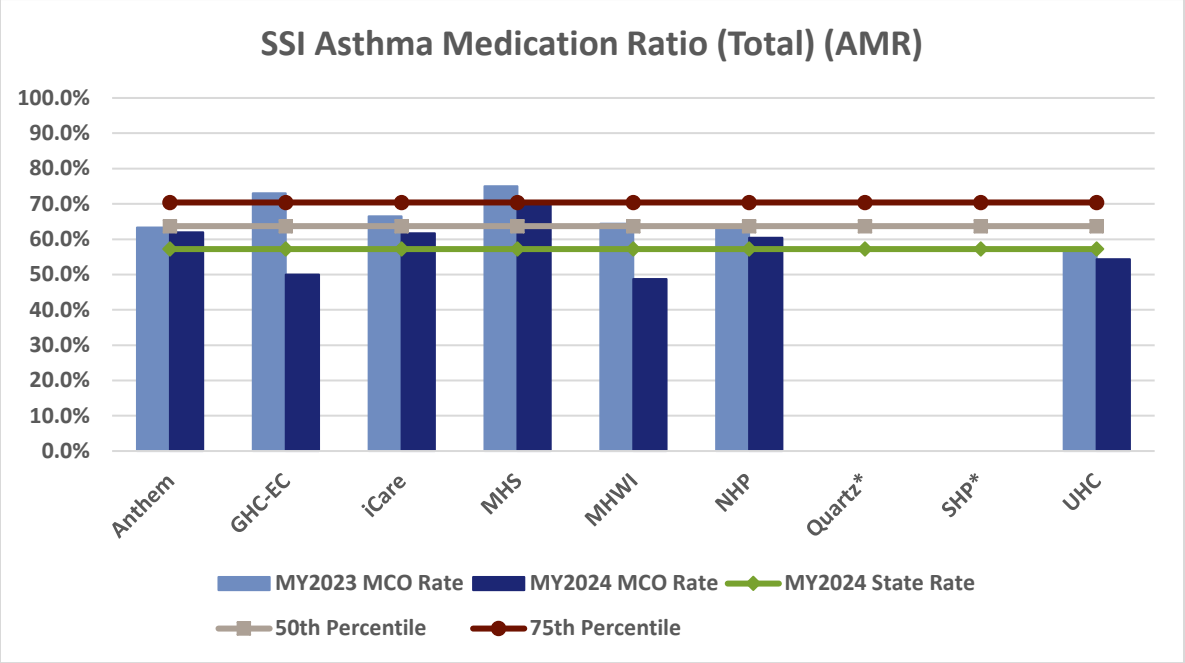
Table 45. SSI Chronic Conditions Performance Measures – MCO Comparison

MCO	AMR - Total	GSD <8.0%
Anthem	61.9%	59.1%
GHC-EC	50.0%	63.2%
*i*Care	61.7%	61.8%
MHS	70.5%	63.7%
MHWI	48.7%	54.7%
NHP	60.4%	65.6%
Quartz	NR	NR
SHP	NR	68.7%
UHC	54.3%	66.2%

NR = Rate not reportable due to denominator <30

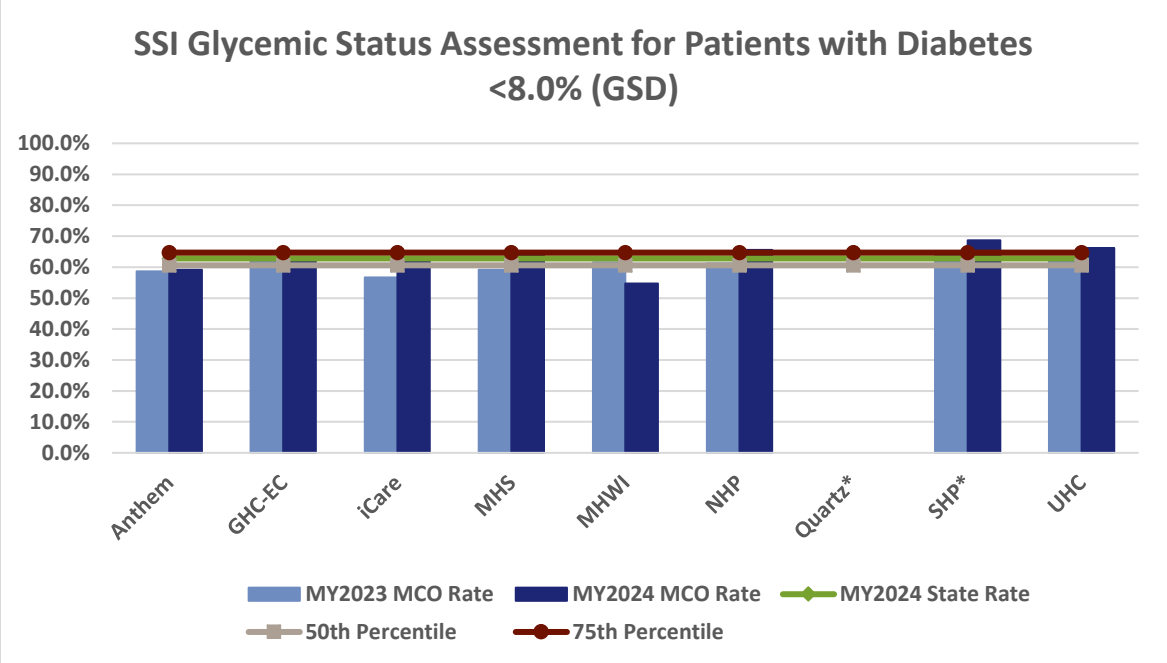
The following graphs illustrate each performance measure as reported by individual MCOs, alongside the statewide aggregate rate and national benchmarks at the 50th and 75th percentiles. This visual comparison highlights how each MCO performs relative to peers within the state and against national standards.

Chart 15. SSI Asthma Medication Ratio (Total) (AMR)



**Denominator <30, not reportable*

Chart 16. SSI Glycemic Status Assessment for Patients with Diabetes <8.0% (GSD) – formerly Hemoglobin A1c Control for Patients with Diabetes (HBD)



**Denominator <30, not reportable*

SSI Behavioral Health

Improving the management of behavioral health involves comprehensive strategies to enhance care, support, and outcomes for individuals facing mental health conditions. The measures are designed to enhance the quality of care, promote better health outcomes, and ensure that enrollees receive the necessary follow-up and preventative care. These measures reflect timeliness, access, and quality. The table below presents the performance rates achieved by each MCO for the measures within this domain.

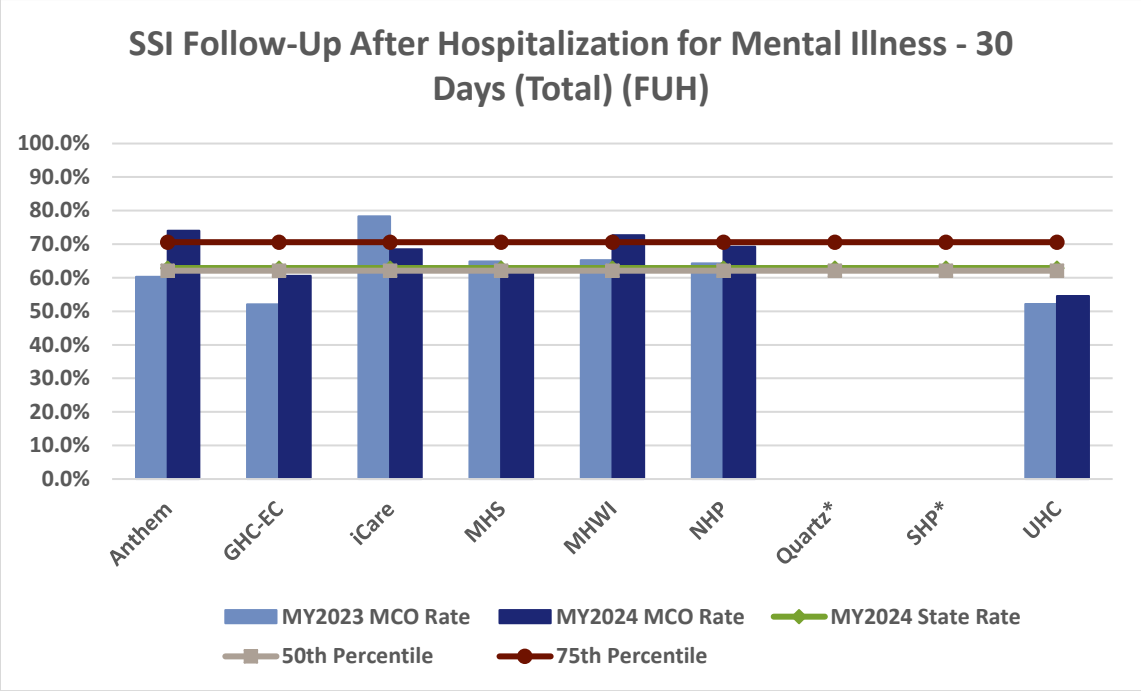
Table 46. SSI Behavioral Health Performance Measures – MCO Comparison

MCO	FUH – 30 Day Total	FUM – 30 Day Total	SSD
Anthem	74.0%	62.3%	80.1%
GHC-EC	60.5%	NR	84.7%
*i*Care	68.4%	55.7%	79.1%
MHS	61.5%	49.1%	78.7%
MHWI	72.7%	73.2%	80.4%
NHP	69.2%	65.6%	75.4%
Quartz	NR	NR	NR
SHP	NR	NR	NR
UHC	54.6%	58.5%	78.4%

NR = Rate not reportable due to denominator <30

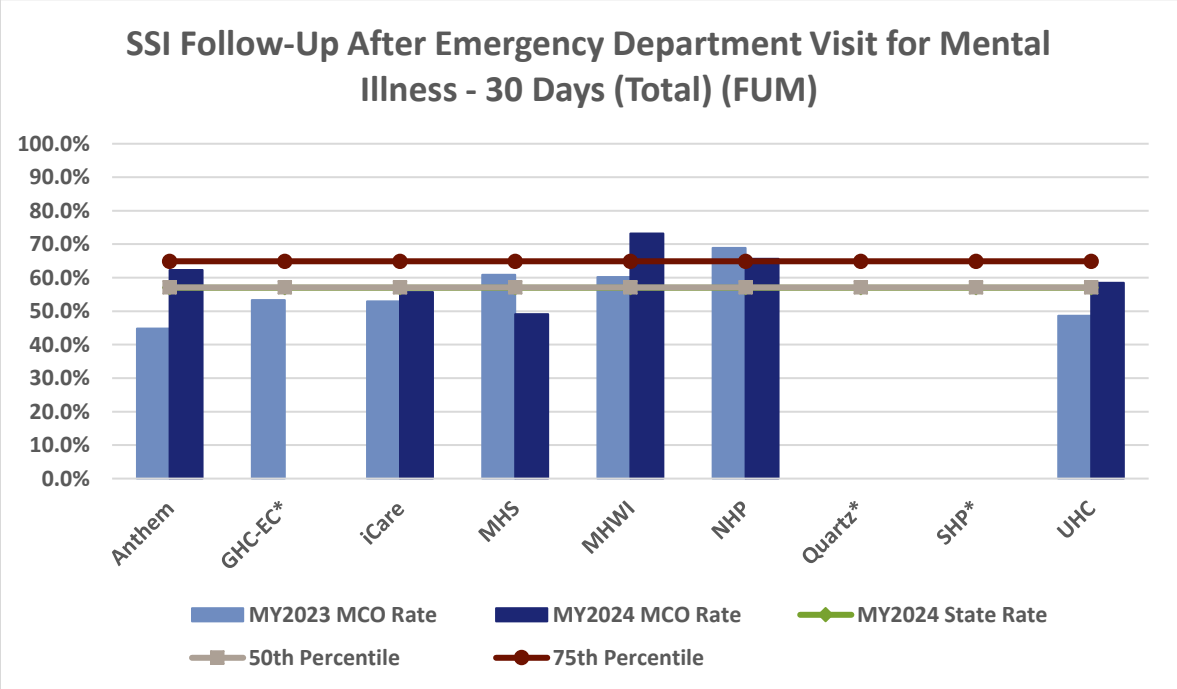
The following graphs illustrate each performance measure as reported by individual MCOs, alongside the statewide aggregate rate and national benchmarks at the 50th and 75th percentiles. This visual comparison highlights how each MCO performs relative to peers within the state and against national standards.

Chart 17. SSI Follow-Up After Hospitalization for Mental Illness - 30 Days (Total) (FUH)



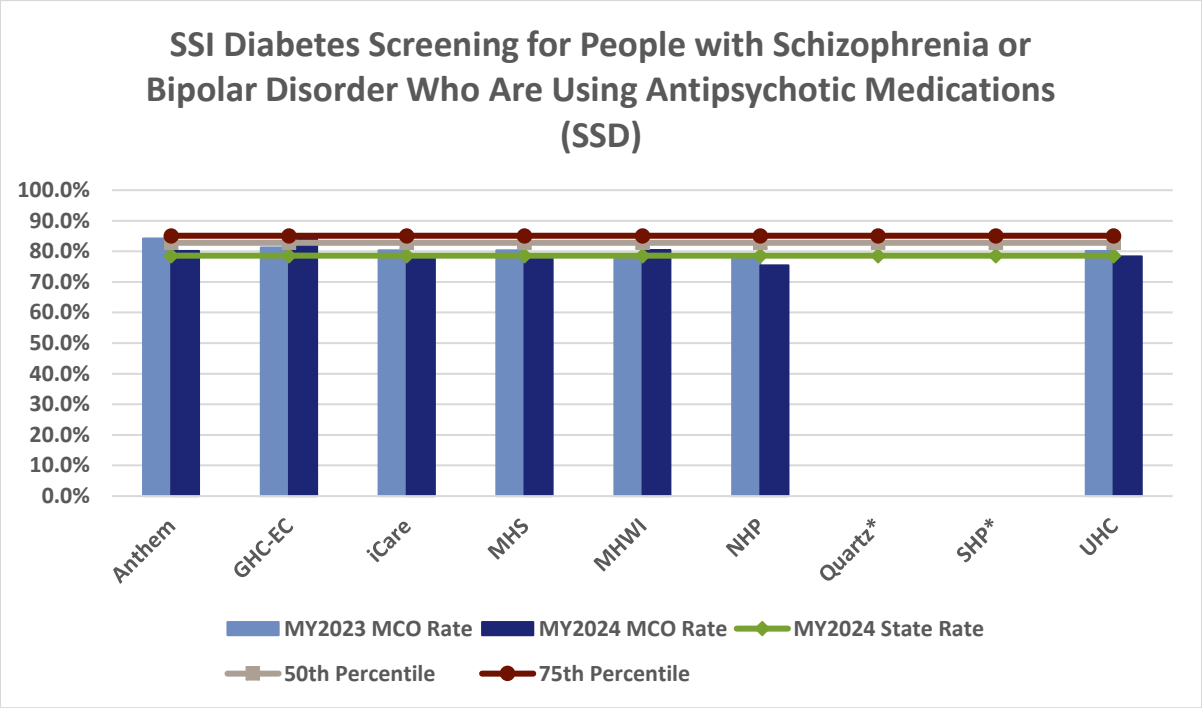
Denominator <30, not reportable

Chart 18. SSI Follow-Up After Emergency Department Visits for Mental Illness - 30 Days (Total) (FUM)



Denominator <30, not reportable

Chart 19. SSI Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)



**Denominator <30, not reportable*

SSI Preventative Health

Promoting preventative care is a proactive apporach to healthcare, designed to improve the quality of life for medically complex SSI enrollees. Preventative health and screening measures relate to whether enrollees receive adequate preventive care needed to prevent chronic conditions or other acute health problems. These measures reflect access and quality. The table below presents the performance rates achieved by each MCO for the measures within this domain.

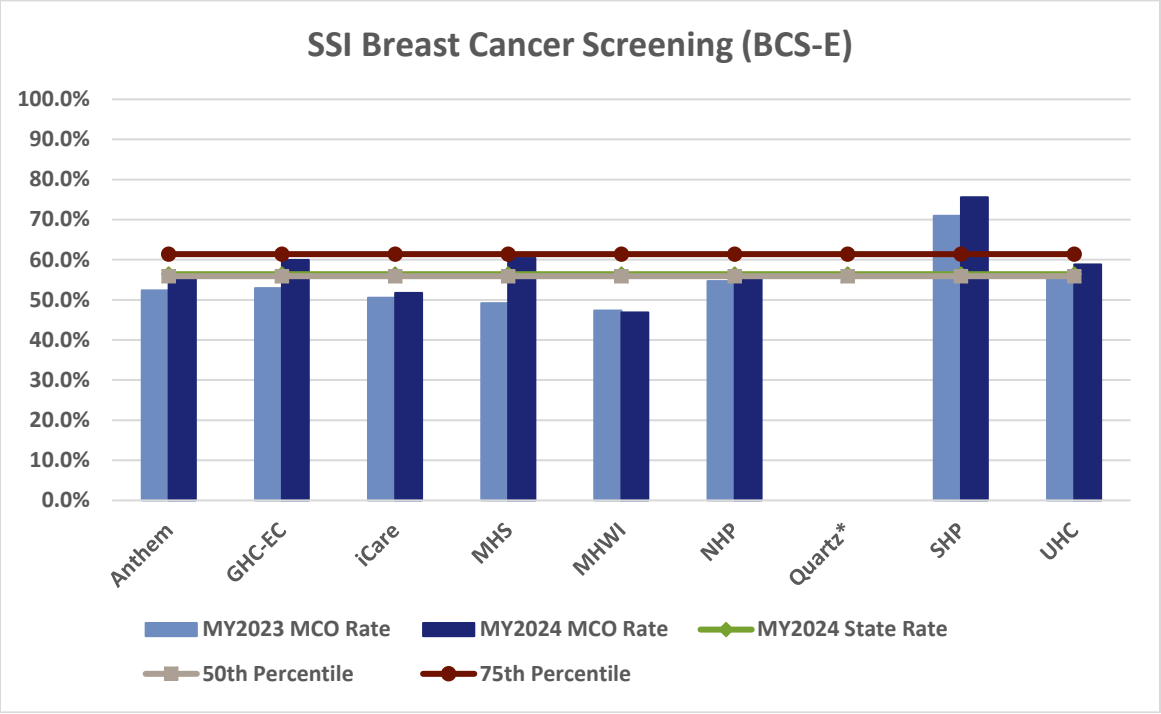
Table 47. SSI Preventative Health Performance Measures – MCO Comparison

MCO	BCS-E	CCS
Anthem	55.7%	57.4%
GHC-EC	59.9%	59.1%
iCare	51.7%	55.2%
MHS	60.5%	62.0%
MHWI	46.8%	55.7%
NHP	56.5%	58.9%
Quartz	NR	30.3%
SHP	75.6%	56.1%
UHC	58.8%	62.5%

NR = Rate not reportable due to denominator <30

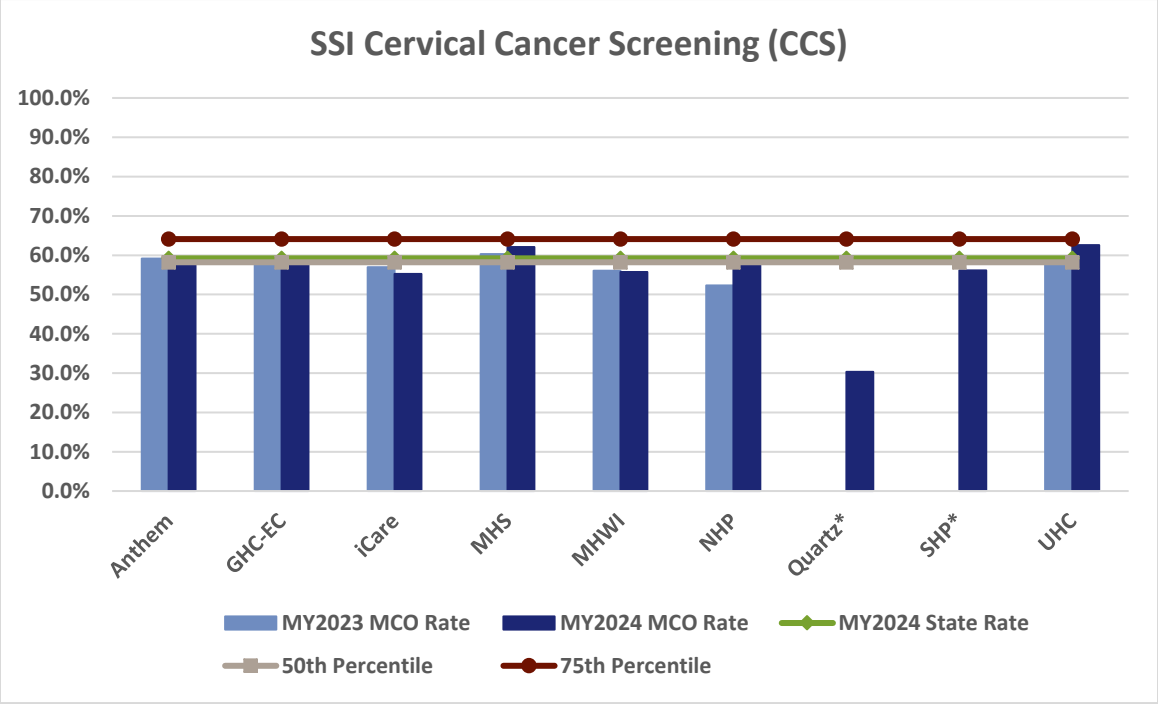
The graphs below illustrate each performance measure as reported by individual MCOs, alongside the statewide aggregate rate and national benchmarks at the 50th and 75th percentiles. This visual comparison highlights how each MCO performs relative to peers within the state and against national standards.

Chart 20. SSI Breast Cancer Screening (BCS-E)



**Denominator <30, not reportable*

Chart 21. SSI Cervical Cancer Screening (CCS)



**Denominator <30, not reportable*

Foster Care Medical Home (Care4Kids) Results

Prioritizing preventative services and care of acute and chronic conditions for children in out-of-home care prompts overall health and developmental wellbeing. Preventative health and screening measures relate to whether enrollees receive adequate preventive care needed to prevent chronic conditions or other acute health problems. Managing acute and chronic conditions reduces adverse outcomes. These measures reflect access and quality. The table below presents the performance rates achieved by Care4Kids for the measures within this domain.

Table 48. FCMH – C4K Performance Measures

Performance Measure	MY 2023 State Rate	MY 2024 State Rate	50th Percentile	75th Percentile	Results
Childhood Immunization Status – Combo 3 (CIS)	74.1%	71.4%	67.4%	72.1%	Compliant
Immunizations for Adolescents – Combo 2 (IMA)	75.3%	72.3%	36.5%	43.6%	Strength

Performance Measure	MY 2023 State Rate	MY 2024 State Rate	50th Percentile	75th Percentile	Results
Lead Screening in Children (LSC)	92.2%	89.8%	70.0%	76.3%	Strength
Outpatient Mental Health Follow-Up 7 Days After Hospitalization for Mental Illness (Ages 6 - 17) (FUH)	36.5%	45.7%	48.9%	57.5%	Opportunity
Outpatient Mental Health Follow-Up 30 Days After Hospitalization for Mental Illness (Ages 6 – 17) (FUH)	52.4%	63.8%	73.6%	79.3%	Opportunity
Outpatient Mental Health Follow-Up 7 Days After ED Visit for Mental Illness (Ages 6 - 17) (FUM)	23.0%	28.8%	50.6%	61.4%	Opportunity
Outpatient Mental Health Follow-Up 30 Days After ED Visit for Mental Illness (Ages 6 - 17) (FUM)	34.4%	38.5%	69.2%	77.4%	Opportunity

The following graphs illustrate each performance measure as reported by the PIHP, alongside the statewide aggregate rate and national benchmarks at the 50th and 75th percentiles. This visual comparison highlights how the FCMH PIHP performs relative to peers within the state and against national standards.

Chart 22. FCMH – C4K Childhood Immunization Status (Combo 3) (CIS)

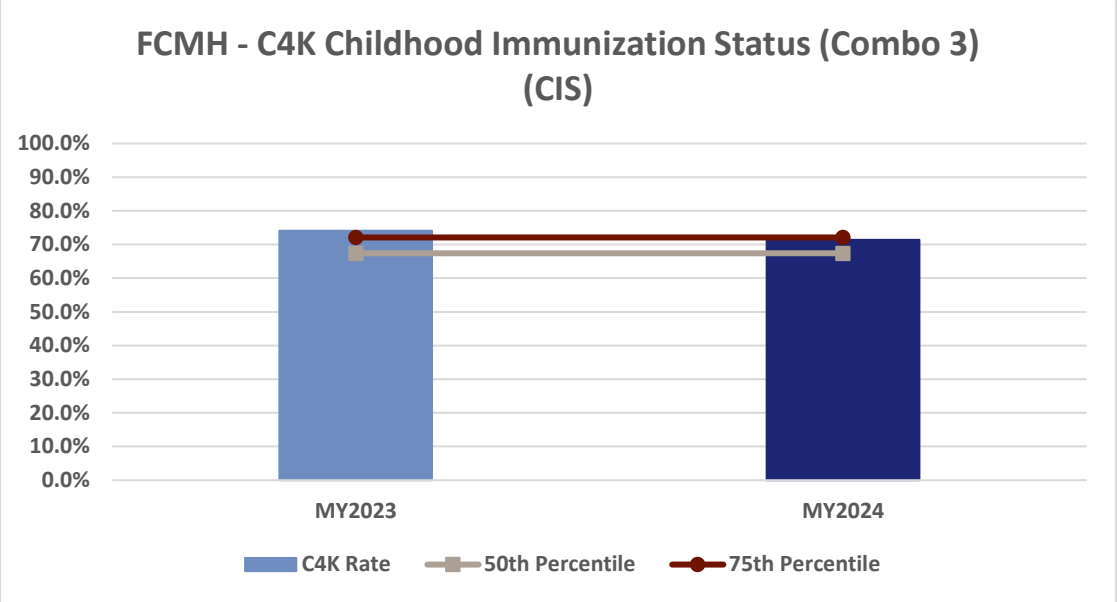


Chart 23. FCMH – C4K Immunizations for Adolescents (Combo 2) (IMA)

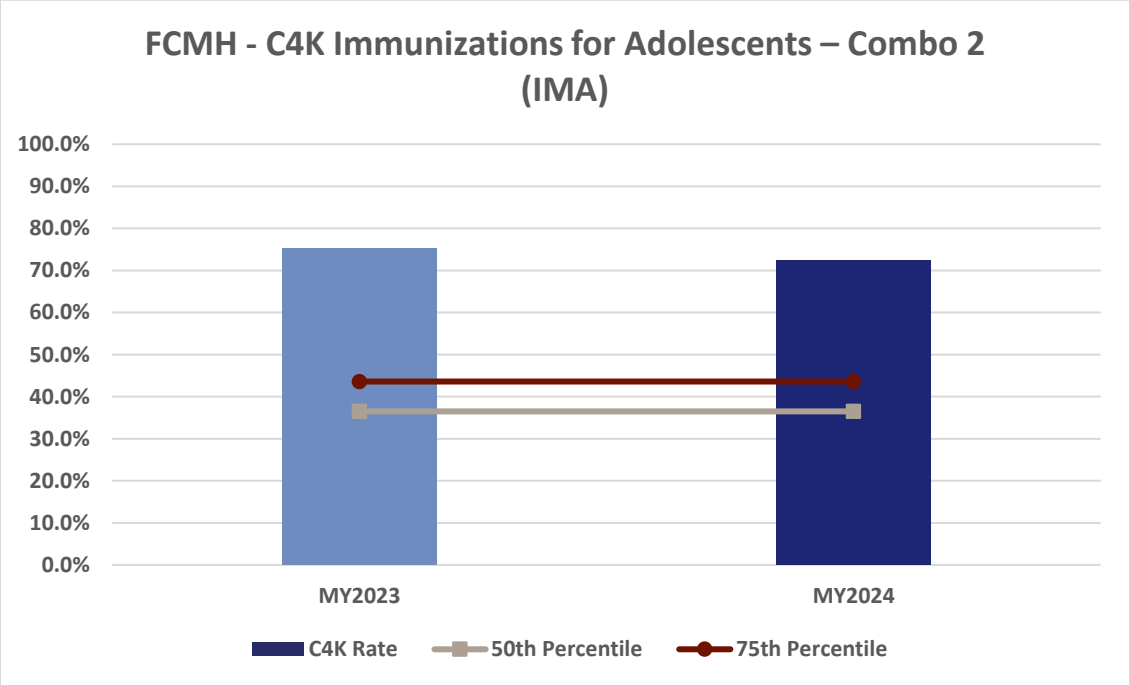


Chart 24. FCMH – C4K Lead Screening in Children (LSC)

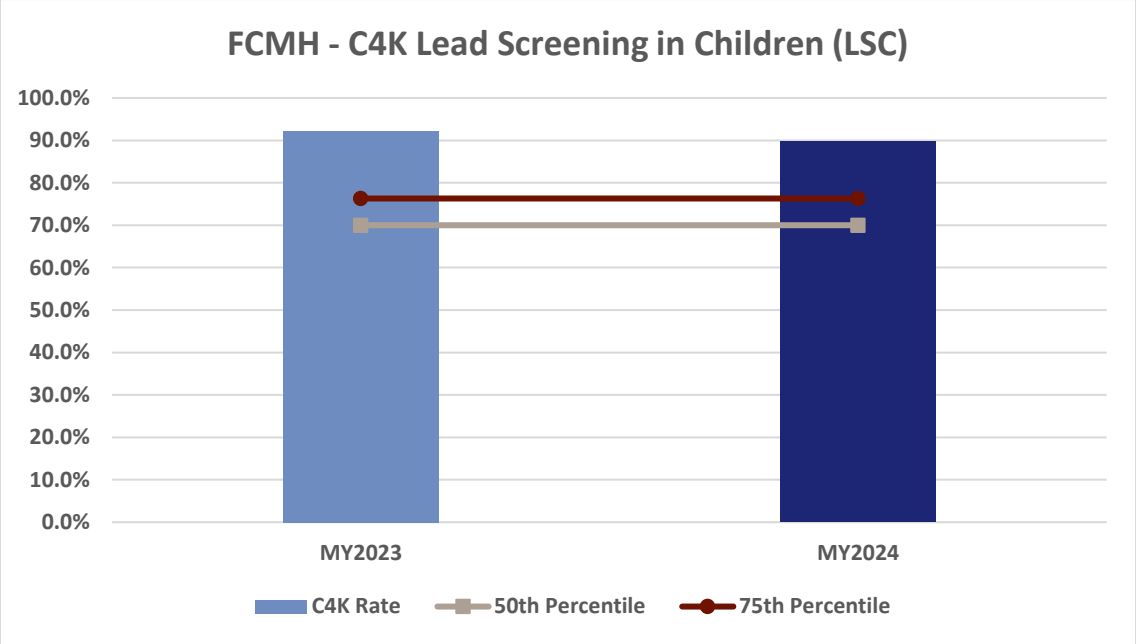


Chart 25. FCMH – C4K Follow-Up After Hospitalization for Mental Illness - 7 Days (Ages 6 – 17) (FUH)

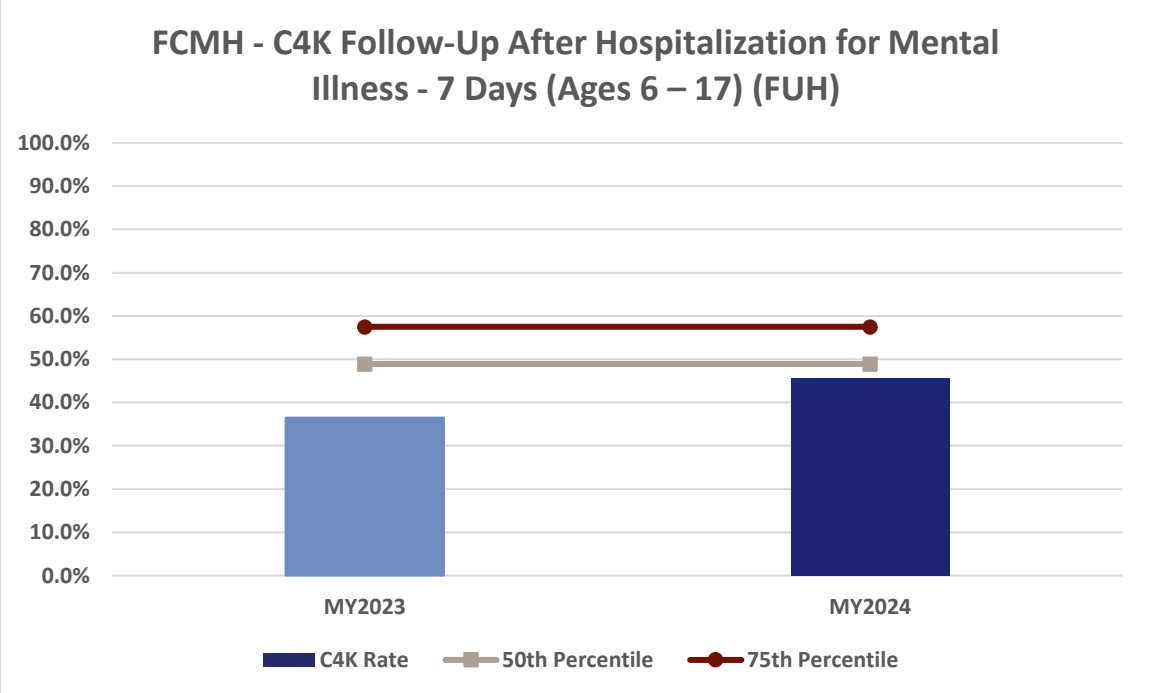


Chart 26. FCMH – C4K Follow-Up After Hospitalization for Mental Illness - 30 Days (Ages 6 – 17) (FUH)

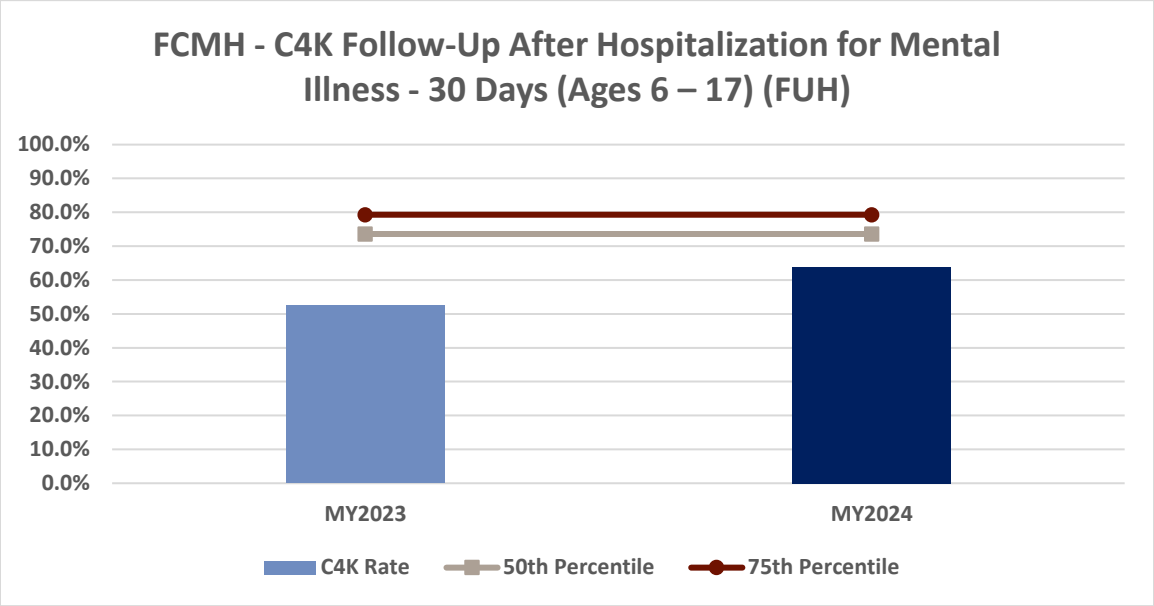


Chart 27. FCMH – C4K Follow-Up After Emergency Department Visits for Mental Illness - 7 Days (Ages 6 – 17) (FUM)

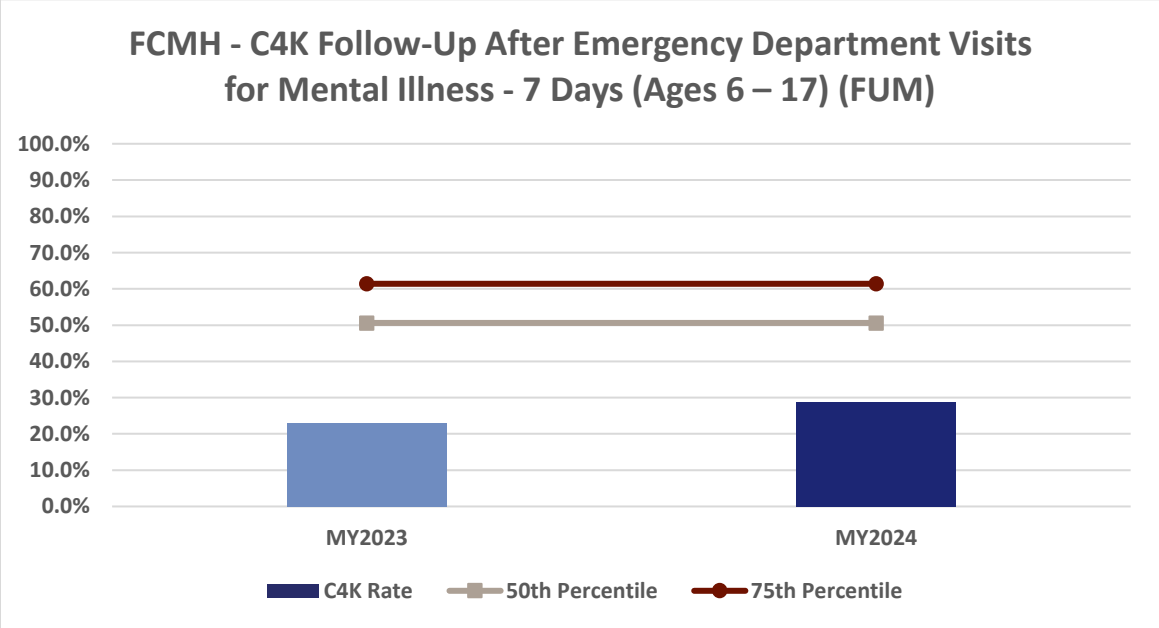
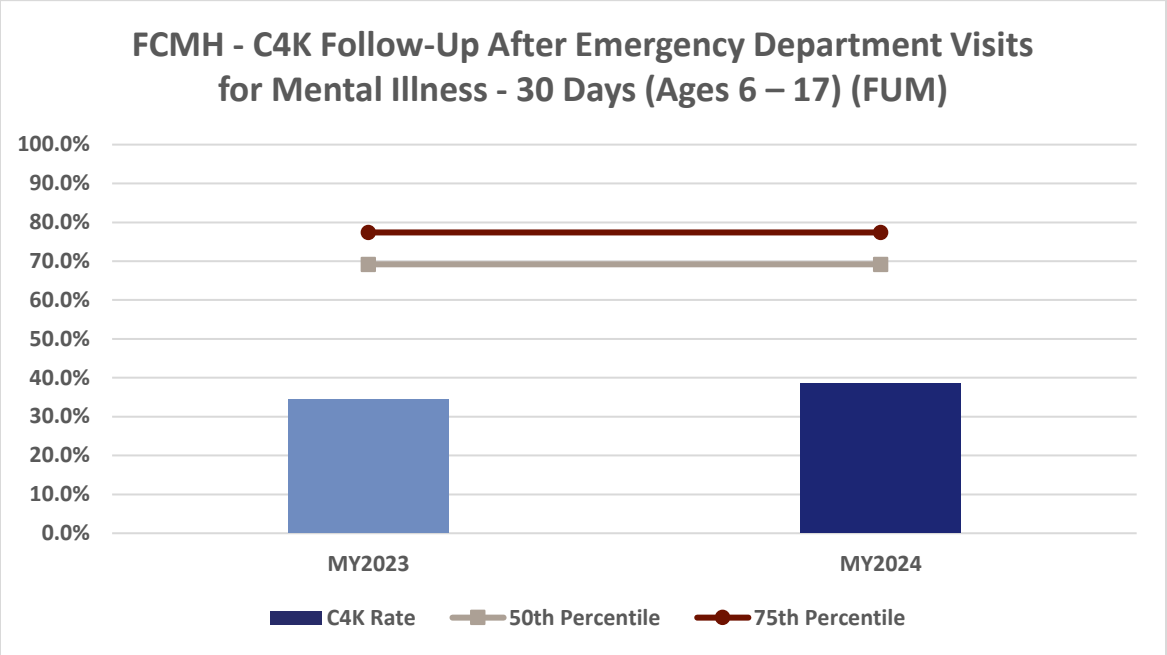


Chart 28. FCMH – C4K Follow-Up After Emergency Department Visits for Mental Illness - 30 Days (Ages 6 – 17) (FUM)



Validation of Performance Measures - State Level Findings

The table below identifies strengths, weaknesses/opportunities for improvement, and recommendations for the performance measures validated in CY 2025. Strengths from the performance measure validation are defined as quality indicator rates at or above the 75th percentile. Weaknesses, or opportunities for improvement, are included for any quality indicator rate that is below the 50th percentile. Recommendations are provided for all identified weaknesses and opportunities for improvement.

Performance falling between the 50th and 74th percentiles is classified as compliant. These measures will not be formally identified as strengths or weaknesses/opportunities for improvement. While these measures meet standard requirements, current outreach and clinical workflows should be maintained to drive performance toward the 75th percentile benchmark.

Table 49. PMV Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
• FCMH demonstrated strengths with the following measures:

Performance Measure Validation

- IMA – Combo 2 achieved high compliance rates for the adolescent vaccine series, demonstrating effective preventative outreach.
- LSC achieved high compliance which signified a robust POC testing culture. This reflects successful provider education and a highly effective reminder system that ensures children are screened for lead exposure by their second birthday.

- No strengths were identified for the BC+ or SSI; performance across all identified measures remained below the 75th percentile benchmark.

Weaknesses/Opportunities for Improvement

- BC+ demonstrated opportunities for improvement in the following measures:
  - CIS – Combo 3: Performance reflects a failure to complete the full 10-vaccine series by the second birthday, indicating a need for more aggressive 'catch-up' scheduling and parent education.
  - IMA – Combo 2: Rankings below the 50th percentile signify a drop-off in adolescent immunization rates (Meningococcal, Tdap, HPV), often due to lower frequency of office visits in this age demographic.
  - AMR – Total: Performance indicates an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations.
  - WCV – Total: Low percentile ranking suggests a decline in annual well-child engagement, potentially driven by fragmented care coordination or barriers to physical office visits.
- SSI demonstrated opportunities for improvement in the following measures:
  - AMR – Total: Performance indicates an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations.
  - SSD: Performance indicated a critical gap in metabolic monitoring for high-risk members on antipsychotic medications. This suggests a lack of coordination between behavioral health providers and primary care to ensure annual A1c or glucose testing.
  - FUH – 30 Days Total: Falling below the 50th percentile reflected an inability to successfully re-engage members in community-based care within 30 days of an inpatient psychiatric discharge. This gap points to a breakdown in discharge planning and inadequate post-discharge outreach.
- FCMH - C4K demonstrated opportunities for improvement in the following measures:
  - FUH – 7- and 30-Days Ages 6 – 17: Performance indicated a critical delay in connecting foster youth to community-based providers following a psychiatric hospitalization. Failing to meet the 7-day "gold standard" significantly increases the risk of readmission and placement disruption.

Performance Measure Validation
○ FUM – 7- and 30-Days Ages 6 – 17: Rankings below the 50th percentile for follow-up after an ED visit for mental illness suggested a lack of rapid-response outpatient appointments. This gap indicates that emergency care is often treated as an isolated event rather than a trigger for intensive care management.
Recommendations
• AMR - Total: ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence. ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management. • CIS, IMA, and WCV: ○ Implement value-added member engagement programs or small incentives to encourage the completion of age-appropriate wellness visits and vaccinations. ○ Provide clinical teams with frequent "gap-to-goal" lists to prioritize scheduling for pediatric and adolescent members approaching key age milestones. • FUH and FUM: ○ Expand the use of telehealth for post-discharge follow-up visits to mitigate common barriers such as transportation and scheduling conflicts. ○ Enhance notification systems for emergency department and inpatient discharges to ensure care managers can coordinate the required seven-day follow-up window. • SSD: ○ Support behavioral health providers in performing or coordinating metabolic screenings (Glucose or A1c) during routine psychiatric visits. ○ Improve the bidirectional sharing of laboratory results between primary care and behavioral health providers to ensure comprehensive monitoring and reduce duplicate testing.

Validation of Performance Measures – Managed Care Organization Level Findings

Anthem Blue Cross and Blue Shield Health Plan

The following results provide an overview of the performance measure validation for Anthem.

Table 50. Anthem Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
• SSI demonstrated strengths with the following measure: ○ FUH – 30 Days Total: Leading the 75th percentile reflected a highly coordinated transition-of-care protocol. This indicates strong partnerships between inpatient psychiatric facilities and outpatient providers, ensuring members remain clinically engaged following a mental health crisis. • No strengths were identified for BC+; performance across all identified measures remained below the 75th percentile benchmark.
Weaknesses/Opportunities for Improvement

• BC+ demonstrated opportunities for improvement in the following measures:
  ○ PPC – Timeliness of Prenatal Care: Performance suggested that members are not accessing clinical care until the second or third trimester. This indicates barriers to early pregnancy identification, delayed health plan notification, or a shortage of immediate OB-GYN appointment availability.
  ○ PPC - Postpartum Care: Rankings below the 50th percentile reflected a sharp decline in clinical engagement following delivery. This gap points to a lack of support during the transition from hospital to home, often exacerbated by childcare challenges, transportation barriers, or a lack of awareness regarding the seven–84 day HEDIS® window.
  ○ AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations.
• SSI demonstrated opportunities for improvement in the following measures:
  ○ AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations.
  ○ GSD <8 percent: Performance indicated that a significant portion of the diabetic population has blood glucose levels exceeding the8.0 percent threshold. This suggests a need for more intensive medication therapy management, improved nutritional counseling, and more frequent lab monitoring to achieve stabilization.
  ○ SSD: Performance indicated a critical gap in metabolic monitoring for high-risk members on antipsychotic medications. This suggests a lack of coordination between behavioral health providers and primary care to ensure annual A1c or glucose testing.
  ○ BCE-E: Performance reflected an opportunity to increase the proportion of women aged 50–74 who had at least one screening mammogram in the past two years. Current rates below the 50th percentile indicated a gap in early detection efforts and a need to address scheduling or access barriers for diagnostic imaging.
  ○ CCS: Performance indicated that a significant number of women aged 21–64 are not receiving regular cervical cytology (Pap tests) or HPV testing within the recommended clinical timeframes. This gap highlighted a need for more robust preventative screenings and member follow-up.

Performance Measure Validation
Recommendations

• PPC – Timeliness of Prenatal Care:
  ○ Collaborate with high-volume obstetric providers to prioritize scheduling for new members, ensuring initial prenatal visits occur shortly after enrollment.
  ○ Strengthen referral pathways with community partners and screening sites to trigger care management outreach immediately following a confirmed pregnancy.
• PPC – Postpartum Care:
  ○ Integrate postpartum follow-up scheduling into the hospital discharge process to ensure the seven–84 day visit is confirmed before the member leaves the facility.
  ○ Expand the use of telehealth for postpartum evaluations to address common social determinants of health, such as childcare needs and transportation challenges.
• AMR - Total:
  ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence.
  ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management.
• GSD <8 percent:
  ○ Support the use of rapid in-office screening tools to ensure immediate clinical results and data capture, reducing reliance on external laboratory follow-ups.
  ○ Expand screening opportunities during routine clinical and pharmacy interactions to create low-barrier access for members.
  ○ Utilize clinical support staff to conduct medication reviews and regimen adjustments for members trending above the8.0 percent threshold
• SSD:
  ○ Support behavioral health providers in performing or coordinating metabolic screenings (Glucose or A1c) during routine psychiatric visits.
  ○ Improve the bidirectional sharing of laboratory results between primary care and behavioral health providers to ensure comprehensive monitoring and reduce duplicate testing.
• BCE-E and CCS:
  ○ Deploy targeted mailings or digital notifications to members due for screenings based on age and clinical history.
  ○ Utilize supplemental data and administrative claims to ensure all screenings performed, including those at specialized clinics, are captured without requiring manual chart pulls.
  ○ Provide clinics with monthly member lists to identify and schedule members during routine office visits or wellness exams.

CCHP - Care4Kids

The following results provide an overview of the performance measure validation for CCHP - C4K.

Table 51. CCHP - C4K Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
• FCMH demonstrated strengths with the following measures: ○ IMA – Combo 2 achieved high compliance rates for the adolescent vaccine series, demonstrating effective preventative outreach. ○ LSC achieved high compliance which signified a robust POC testing culture. This reflects successful provider education and a highly effective reminder system that ensures children are screened for lead exposure by their second birthday.
Weaknesses/Opportunities for Improvement
• FCMH demonstrated opportunities for improvement in the following measures: ○ FUH – 7- and 30-Days Ages 6 – 17: Performance indicated a critical delay in connecting foster youth to community-based providers following a psychiatric hospitalization. Failing to meet the 7-day "gold standard" significantly increases the risk of readmission and placement disruption. ○ FUM – 7- and 30-Days Ages 6 – 17: Rankings below the 50th percentile for follow-up after an ED visit for mental illness suggested a lack of rapid-response outpatient appointments. This gap indicates that emergency care is often treated as an isolated event rather than a trigger for intensive care management.
Recommendations
• FUH and FUM: ○ Expand the use of telehealth for post-discharge follow-up visits to mitigate common barriers such as transportation and scheduling conflicts. ○ Enhance notification systems for emergency department and inpatient discharges to ensure care managers can coordinate the required seven-day follow-up window

Chorus Community Health Plan Health Plan

The following results provide an overview of the performance measure validation for CCHP.

Table 52. CCHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
BC+ demonstrated strengths in the following measures: • LSC: Achieving the 75th percentile signified a robust POC testing culture. This reflects successful provider education and a highly effective reminder system that ensures children are screened for lead exposure by their second birthday. • PPC – Postpartum Care: Performance above the 75th percentile indicated a seamless transition from delivery to community-based care. This suggests high member awareness and effective discharge planning that successfully captures the critical seven–84 day follow-up window.

Performance Measure Validation
• FUH – 30 Days Total: Leading the 75th percentile reflected a highly coordinated transition-of-care protocol. This indicates strong partnerships between inpatient psychiatric facilities and outpatient providers, ensuring members remain clinically engaged following a mental health crisis.
Weaknesses/Opportunities for Improvement
BC+ demonstrated opportunities for improvement in the following measures: • CIS – Combo 3: Performance reflected a failure to complete the full 10-vaccine series by the second birthday, indicating a need for more aggressive 'catch-up' scheduling and parent education. • AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations.
Recommendations
• CIS – Combo 3: ○ Enhance "catch-up" scheduling protocols to ensure all pediatric members complete the required vaccine series before their second birthday. ○ Develop and distribute age-specific educational resources for parents and caregivers to emphasize the importance of timely adherence to the full immunization schedule. • AMR - Total: ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence. ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management.

Dean Health Plan, Inc.

The following results provide an overview of the performance measure validation for DHP.

Table 53. DHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
BC+ demonstrated strengths in the following measures: • PPC – Timeliness of Prenatal Care: Exceeding the 75th percentile confirmed that members are successfully navigating the healthcare system early in their pregnancy. This indicates high efficiency in pregnancy notification workflows and strong provider availability for initial OB appointments.
Weaknesses/Opportunities for Improvement
BC+ demonstrated opportunities for improvement in the following measures: • AMR - Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations. • GSD <8 percent: Performance indicated that a significant portion of the diabetic population has blood glucose levels exceeding the8.0 percent threshold. This suggests a need for more intensive medication therapy management, improved nutritional counseling, and more frequent lab monitoring to achieve stabilization.

Performance Measure Validation
• FUH – 30 Days Total: Falling below the 50th percentile for the 30-day follow-up window reflected a failure to re-establish outpatient clinical contact after an inpatient psychiatric stay. This suggests that members lose connection with their care teams during the vulnerable month following a crisis, heightening the risk of relapse.
Recommendations

• AMR - Total:
  ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence.
  ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management.
• GSD <8 percent:
  ○ Support the use of rapid in-office screening tools to ensure immediate clinical results and data capture, reducing reliance on external laboratory follow-ups.
  ○ Expand screening opportunities during routine clinical and pharmacy interactions to create low-barrier access for members.
  ○ Utilize clinical support staff to conduct medication reviews and regimen adjustments for members trending above the 8.0% threshold.
• FUH – 30 Days Total:
  ○ Expand the use of telehealth for post-discharge follow-up visits to mitigate common barriers such as transportation and scheduling conflicts.
  ○ Enhance notification systems for emergency department and inpatient discharges to ensure care managers can coordinate the required seven-day follow-up window.

Group Health Cooperative of Eau Claire

The following results provide an overview of the performance measure validation for GHC-EC.

Table 54. GHC-EC Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
BC+ demonstrated strengths in the following measures: • PPC – Timeliness of Prenatal Care: Exceeding the 75th percentile confirmed that members are successfully navigating the healthcare system early in their pregnancy. This indicates high efficiency in pregnancy notification workflows and strong provider availability for initial OB appointments. • PPC – Postpartum Care: Performance above the 75th percentile indicated a seamless transition from delivery to community-based care. This suggests high member awareness and effective discharge planning that successfully captures the critical seven–84 day follow-up window. • GSD <8 percent: Exceeding the 75th percentile confirmed that most diabetic members are maintaining blood glucose levels within a safe, stable range. This suggests that providers are successfully adjusting treatment plans and that members have reliable access to necessary medications and supplies. High performance in this measure indicates a seamless flow of data

Performance Measure Validation
between external laboratories, provider EHRs, and the health plan, ensuring that nearly all successful screenings are captured and reported accurately. No strengths were identified for SSI; performance across all identified measures remained below the 75th percentile benchmark.
Weaknesses/Opportunities for Improvement
BC+ demonstrated opportunities for improvement in the following measures: • CIS – Combo 3: Performance reflected a failure to complete the full 10-vaccine series by the second birthday, indicating a need for more aggressive 'catch-up' scheduling and parent education. • LSC: Performance below the 50th percentile reflected a failure to ensure that children receive a blood lead test by their second birthday. This gap indicates a potential risk for undetected environmental lead exposure, which can lead to permanent developmental and neurological impairments. • WCV – Total: Low percentile ranking suggested a decline in annual well-child engagement, potentially driven by fragmented care coordination or barriers to physical office visits. • FUH – 30 Days Total: Falling below the 50th percentile for the 30-day follow-up window reflected a failure to re-establish outpatient clinical contact after an inpatient psychiatric stay. This suggests that members lose connection with their care teams during the vulnerable month following a crisis, heightening the risk of relapse. SSI demonstrated opportunities for improvement in the following measures: • AMR - Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbation. • FUH – 30 Days Total: Falling below the 50th percentile reflected an inability to successfully re-engage members in community-based care within 30 days of an inpatient psychiatric discharge. This gap points to a breakdown in discharge planning and inadequate post-discharge outreach
Recommendations

• CIS – Combo 3:
  ○ Implement proactive scheduling and outreach to ensure all components of the multi-vaccine series are completed by the second birthday.
  ○ Develop targeted communication materials for parents highlighting the clinical importance of completing the full series on schedule.
• LSC:
  ○ Support the adoption of in-office capillary blood testing to allow for immediate screening and gap closure during routine pediatric visits.
  ○ Enhance data-sharing workflows with public health departments and community programs to capture results performed outside the primary care setting.
  ○ Utilize geographic and demographic data to deploy educational mailers to members in high-risk areas, emphasizing the developmental necessity of screening.
• WCV -Total:
  ○ Incorporate telehealth for the behavioral and mental health components of wellness visits to increase flexibility and reduce in-person visit duration.
  ○ Provide clinical sites with bi-monthly gap-to-goal reports to prioritize scheduling for members approaching key age milestones.

Performance Measure Validation

• FUH – 30 Days Total:
  ○ Expand the use of telehealth for post-discharge follow-up visits to mitigate common barriers such as transportation and scheduling conflicts.
  ○ Enhance notification systems for emergency department and inpatient discharges to ensure care managers can coordinate the required seven-day follow-up window.
• AMR - Total:
  ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence.
  ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management.

Group Health Cooperative of South-Central Wisconsin

The following results provide an overview of the performance measure validation for GHC-SCW.

Table 55. GHC-SCW Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
BC+ demonstrated strengths in the following measures: • GSD <8 percent: Exceeding the 75th percentile confirmed that most diabetic members are maintaining blood glucose levels within a safe, stable range. This suggests that providers are successfully adjusting treatment plans and that members have reliable access to necessary medications and supplies. High performance in this measure indicates a seamless flow of data between external laboratories, provider EHRs, and the health plan, ensuring that nearly all successful screenings are captured and reported accurately.
Weaknesses/Opportunities for Improvement
BC+ demonstrated opportunities for improvement in the following measures: • CIS – Combo 3: Performance reflected a failure to complete the full 10-vaccine series by the second birthday, indicating a need for more aggressive 'catch-up' scheduling and parent education. • LSC: Performance below the 50th percentile reflected a failure to ensure that children receive a blood lead test by their second birthday. This gap indicates a potential risk for undetected environmental lead exposure, which can lead to permanent developmental and neurological impairments. • WCV – Total: Low percentile ranking suggested a decline in annual well-child engagement, potentially driven by fragmented care coordination or barriers to physical office visits. • PPC – Timeliness of Prenatal Care: Performance suggested that members are not accessing clinical care until the second or third trimester. This indicates barriers to early pregnancy identification, delayed health plan notification, or a shortage of immediate OB-GYN appointment availability. • PPC - Postpartum Care: Rankings below the 50th percentile reflected a sharp decline in clinical engagement following delivery. This gap points to a lack of support during the transition from hospital to home, often exacerbated by childcare challenges, transportation barriers, or a lack of awareness regarding the seven–84 day HEDIS® window.

Performance Measure Validation
• AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations. • CBP: Performance indicated that members diagnosed with hypertension are frequently remaining in a high-risk clinical state. This increases the population-level risk for acute cardiovascular events, such as stroke or myocardial infarction. Falling below the 50th percentile often reflects a 'data gap' where blood pressure readings taken during office visits are not being accurately coded (using CPT II codes) or shared with the plan, resulting in compliant members being erroneously counted as non-compliant.
Recommendations

• CIS – Combo 3:
  ○ Implement proactive scheduling and outreach to ensure all components of the multi-vaccine series are completed by the second birthday.
  ○ Develop targeted communication materials for parents highlighting the clinical importance of completing the full series on schedule.
• LSC:
  ○ Support the adoption of in-office capillary blood testing to allow for immediate screening and gap closure during routine pediatric visits.
  ○ Enhance data-sharing workflows with public health departments and community programs to capture results performed outside the primary care setting.
  ○ Utilize geographic and demographic data to deploy educational mailers to members in high-risk areas, emphasizing the developmental necessity of screening.
• WCV -Total:
  ○ Incorporate telehealth for the behavioral and mental health components of wellness visits to increase flexibility and reduce in-person visit duration.
  ○ Provide clinical sites with bi-monthly gap-to-goal reports to prioritize scheduling for members approaching key age milestones.
• PPC – Timeliness of Prenatal Care:
  ○ Collaborate with high-volume obstetric providers to prioritize scheduling for new members, ensuring initial prenatal visits occur shortly after enrollment.
  ○ Strengthen referral pathways with community partners and screening sites to trigger care management outreach immediately following a confirmed pregnancy.
• PPC – Postpartum Care:
  ○ Integrate postpartum follow-up scheduling into the hospital discharge process to ensure the seven–84 day visit is confirmed before the member leaves the facility.
  ○ Expand the use of telehealth for postpartum evaluations to address common social determinants of health, such as childcare needs and transportation challenges.
• AMR - Total:
  ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence.
  ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management.
• CBP:

Performance Measure Validation
○ Educate provider offices on the use of supplemental reporting codes to capture actual blood pressure values on claims, reducing the need for manual medical record reviews. ○ Train clinical staff to perform and document a second blood pressure reading if the initial result is elevated, ensuring the most accurate daily value is recorded for compliance. ○ Expand access to validated home-based blood pressure monitoring for high-risk members to capture stable readings and mitigate "white coat" effects during office visits, a phenomenon where a patient's blood pressure readings are significantly higher in a doctor's office than they are in their daily life. ○ Utilize clinical support teams to identify members with low medication adherence and resolve specific barriers such as side effects, cost, or pharmacy access.

Independent Care Health Plan

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

Table 56. *i*Care Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
BC+ demonstrated strengths in the following measures: • LSC: Achieving the 75th percentile signified a robust POC testing culture. This reflects successful provider education and a highly effective reminder system that ensures children are screened for lead exposure by their second birthday. No strengths were identified for SSI; performance across all identified measures remained below the 75th percentile benchmark.
Weaknesses/Opportunities for Improvement
BC+ demonstrated opportunities for improvement in the following measures: • CIS – Combo 3: Performance reflected a failure to complete the full 10-vaccine series by the second birthday, indicating a need for more aggressive 'catch-up' scheduling and parent education. • IMA – Combo 2: Rankings below the 50th percentile signified a drop-off in adolescent immunization rates (Meningococcal, Tdap, HPV), often due to lower frequency of office visits in this age demographic. • WCV – Total: Low percentile ranking suggested a decline in annual well-child engagement, potentially driven by fragmented care coordination or barriers to physical office visits. • PPC – Timeliness of Prenatal Care: Performance suggested that members are not accessing clinical care until the second or third trimester. This indicates barriers to early pregnancy identification, delayed health plan notification, or a shortage of immediate OB-GYN appointment availability. • PPC - Postpartum Care: Rankings below the 50th percentile reflected a sharp decline in clinical engagement following delivery. This gap points to a lack of support during the transition from hospital to home, often exacerbated by childcare challenges, transportation barriers, or a lack of awareness regarding the seven–84 day HEDIS® window.

Performance Measure Validation
• AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations. • GSD <8 percent: Performance indicated that a significant portion of the diabetic population has blood glucose levels exceeding the 8.0 percent threshold. This suggests a need for more intensive medication therapy management, improved nutritional counseling, and more frequent lab monitoring to achieve stabilization. • CBP: Performance indicated that members diagnosed with hypertension are frequently remaining in a high-risk clinical state. This increases the population-level risk for acute cardiovascular events, such as stroke or myocardial infarction. Falling below the 50th percentile often reflects a 'data gap' where blood pressure readings taken during office visits are not being accurately coded (using CPT II codes) or shared with the plan, resulting in compliant members being erroneously counted as non-compliant. • FUH – 30 Days Total: Falling below the 50th percentile for the 30-day follow-up window reflected a failure to re-establish outpatient clinical contact after an inpatient psychiatric stay. This suggests that members lose connection with their care teams during the vulnerable month following a crisis, heightening the risk of relapse. SSI demonstrated opportunities for improvement in the following measures: • AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbation. • FUM – 30 Day Total: Performance indicated that a significant portion of members did not receive a follow-up visit with a healthcare provider within 30 days of an emergency department discharge for a mental health diagnosis. This gap suggests that emergency visits are not consistently being used as a catalyst for long-term outpatient stabilization, increasing the risk of subsequent crises or re-hospitalization. • SSD: Performance indicated a critical gap in metabolic monitoring for high-risk members on antipsychotic medications. This suggests a lack of coordination between behavioral health providers and primary care to ensure annual A1c or glucose testing. • BCE-E: Performance reflected an opportunity to increase the proportion of women aged 50–74 who had at least one screening mammogram in the past two years. Current rates below the 50th percentile indicated a gap in early detection efforts and a need to address scheduling or access barriers for diagnostic imaging. • CCS: Performance indicated that a significant number of women aged 21–64 are not receiving regular cervical cytology (Pap tests) or HPV testing within the recommended clinical timeframes. This gap highlighted a need for more robust preventative screenings and member follow-up.
Recommendations

• CIS, IMA, and WCV:
  ○ Implement value-added member engagement programs or small incentives to encourage the completion of age-appropriate wellness visits and vaccinations.
  ○ Provide clinical teams with frequent "gap-to-goal" lists to prioritize scheduling for pediatric and adolescent members approaching key age milestones.
• PPC – Timeliness of Prenatal Care:

- Collaborate with high-volume obstetric providers to prioritize scheduling for new members, ensuring initial prenatal visits occur shortly after enrollment.
- Strengthen referral pathways with community partners and screening sites to trigger care management outreach immediately following a confirmed pregnancy.

- PPC – Postpartum Care:
  - Integrate postpartum follow-up scheduling into the hospital discharge process to ensure the seven–84 day visit is confirmed before the member leaves the facility.
  - Expand the use of telehealth for postpartum evaluations to address common social determinants of health, such as childcare needs and transportation challenges.
- AMR - Total:
  - Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence.
  - Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management.
- GSD <8 percent:
  - Support the use of rapid in-office screening tools to ensure immediate clinical results and data capture, reducing reliance on external laboratory follow-ups.
  - Expand screening opportunities during routine clinical and pharmacy interactions to create low-barrier access for members.
  - Utilize clinical support staff to conduct medication reviews and regimen adjustments for members trending above the 8.0 percent threshold.
- CBP:
  - Educate provider offices on the use of supplemental reporting codes to capture actual blood pressure values on claims, reducing the need for manual medical record reviews.
  - Train clinical staff to perform and document a second blood pressure reading if the initial result is elevated, ensuring the most accurate daily value is recorded for compliance.
  - Expand access to validated home-based blood pressure monitoring for high-risk members to capture stable readings and mitigate "white coat" effects during office visits, a phenomenon where a patient’s blood pressure readings are significantly higher in a doctor's office than they are in their daily life.
  - Utilize clinical support teams to identify members with low medication adherence and resolve specific barriers such as side effects, cost, or pharmacy access.
- FUH – 30 Days Total and FUM – 30 Days Total:
  - Expand the use of telehealth for post-discharge follow-up visits to mitigate common barriers such as transportation and scheduling conflicts.
  - Enhance notification systems for emergency department and inpatient discharges to ensure care managers can coordinate the required seven-day follow-up window.
- SSD:
  - Support behavioral health providers in performing or coordinating metabolic screenings (Glucose or A1c) during routine psychiatric visits.
  - Improve the bidirectional sharing of laboratory results between primary care and behavioral health providers to ensure comprehensive monitoring and reduce duplicate testing.

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• BCE-E and CCS:
  ○ Deploy targeted mailings or digital notifications to members due for screenings based on age and clinical history.
  ○ Utilize supplemental data and administrative claims to ensure all screenings performed, including those at specialized clinics, are captured without requiring manual chart pulls.
  ○ Provide clinics with monthly member lists to identify and schedule members during routine office visits or wellness exams

MercyCare Health Plans

The following results provide an overview of the performance measure validation for MCHP.

Table 57. MCHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
BC+ demonstrated strengths in the following measures: • PPC – Timeliness of Prenatal Care: Exceeding the 75th percentile confirmed that members are successfully navigating the healthcare system early in their pregnancy. This indicates high efficiency in pregnancy notification workflows and strong provider availability for initial OB appointments. • PPC – Postpartum Care: Performance above the 75th percentile indicated a seamless transition from delivery to community-based care. This suggests high member awareness and effective discharge planning that successfully captures the critical seven–84 day follow-up window. • CBP: Achieved performance above the 75th percentile reflected effective hypertension management and accurate clinical documentation.
Weaknesses/Opportunities for Improvement
BC+ demonstrated opportunities for improvement in the following measures: • CIS – Combo 3: Performance reflected a failure to complete the full 10-vaccine series by the second birthday, indicating a need for more aggressive 'catch-up' scheduling and parent education. • LSC: Performance below the 50th percentile reflected a failure to ensure that children receive a blood lead test by their second birthday. This gap indicates a potential risk for undetected environmental lead exposure, which can lead to permanent developmental and neurological impairments. • WCV – Total: Low percentile ranking suggested a decline in annual well-child engagement, potentially driven by fragmented care coordination or barriers to physical office visits. • AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations. • GSD <8 percent: Performance indicated that a significant portion of the diabetic population has blood glucose levels exceeding the 8.0 percent threshold. This suggests a need for more intensive medication therapy management, improved nutritional counseling, and more frequent lab monitoring to achieve stabilization.

Performance Measure Validation
• FUH – 30 Days Total: Falling below the 50th percentile reflected an inability to successfully re-engage members in community-based care within 30 days of an inpatient psychiatric discharge. This gap points to a breakdown in discharge planning and inadequate post-discharge outreach.
Recommendations

• CIS – Combo 3:
  ○ Enhance "catch-up" scheduling protocols to ensure all pediatric members complete the required vaccine series before their second birthday.
  ○ Develop and distribute age-specific educational resources for parents and caregivers to emphasize the importance of timely adherence to the full immunization schedule
• LSC:
  ○ Support the adoption of in-office capillary blood testing to allow for immediate screening and gap closure during routine pediatric visits.
  ○ Enhance data-sharing workflows with public health departments and community programs to capture results performed outside the primary care setting.
  ○ Utilize geographic and demographic data to deploy educational mailers to members in high-risk areas, emphasizing the developmental necessity of screening
• WCV -Total:
  ○ Incorporate telehealth for the behavioral and mental health components of wellness visits to increase flexibility and reduce in-person visit duration.
  ○ Provide clinical sites with bi-monthly gap-to-goal reports to prioritize scheduling for members approaching key age milestones.
• AMR - Total:
  ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence.
  ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management.
• GSD <8 percent:
  ○ Support the use of rapid in-office screening tools to ensure immediate clinical results and data capture, reducing reliance on external laboratory follow-ups.
  ○ Expand screening opportunities during routine clinical and pharmacy interactions to create low-barrier access for members.
  ○ Utilize clinical support staff to conduct medication reviews and regimen adjustments for members trending above the 8.0 percent threshold.
• FUH – 30 Days Total:
  ○ Expand the use of telehealth for post-discharge follow-up visits to mitigate common barriers such as transportation and scheduling conflicts.
  ○ Enhance notification systems for emergency department and inpatient discharges to ensure care managers can coordinate the required seven-day follow-up window.

MHS Health Wisconsin

The following results provide an overview of the performance measure validation for MHS.

Table 58. MHS Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
BC+ demonstrated strengths in the following measure: • LSC: Achieving above the 75th percentile signified a robust POC testing culture. This reflects successful provider education and a highly effective reminder system that ensures children are screened for lead exposure by their second birthday. SSI demonstrated strengths in the following measure: • AMR – Total: Performance indicated that members with persistent asthma are effectively balancing their treatments by maintaining a ratio of controller medications to total asthma medications of 0.50 or greater. This high level of performance signifies a successful clinical focus on long-term maintenance therapy rather than an over-reliance on rescue inhalers, which is a critical factor in preventing acute exacerbations and reducing asthma-related emergency department visits.
Weaknesses/Opportunities for Improvement
BC+ demonstrated opportunities for improvement in the following measures: • CIS – Combo 3: Performance reflected a failure to complete the full 10-vaccine series by the second birthday, indicating a need for more aggressive 'catch-up' scheduling and parent education. • IMA – Combo 2: Rankings below the 50th percentile signified a drop-off in adolescent immunization rates (Meningococcal, Tdap, HPV), often due to lower frequency of office visits in this age demographic. • WCV – Total: Low percentile ranking suggested a decline in annual well-child engagement, potentially driven by fragmented care coordination or barriers to physical office visits. • AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations. • GSD <8 percent: Performance indicated that a significant portion of the diabetic population has blood glucose levels exceeding the 8.0 percent threshold. This suggests a need for more intensive medication therapy management, improved nutritional counseling, and more frequent lab monitoring to achieve stabilization. SSI demonstrated opportunities for improvement in the following measures: • FUH – 30 Days Total: Falling below the 50th percentile reflected an inability to successfully re-engage members in community-based care within 30 days of an inpatient psychiatric discharge. This gap points to a breakdown in discharge planning and inadequate post-discharge outreach. • FUM – 30 Day Total: Performance indicated that a significant portion of members did not receive a follow-up visit with a healthcare provider within 30 days of an emergency department discharge for a mental health diagnosis. This gap suggests that emergency visits are not consistently being used as a catalyst for long-term outpatient stabilization, increasing the risk of subsequent crises or re-hospitalization. • SSD: Performance indicated a critical gap in metabolic monitoring for high-risk members on antipsychotic medications. This suggests a lack of coordination between behavioral health providers and primary care to ensure annual A1c or glucose testing.
Recommendations

Performance Measure Validation

• CIS, IMA, and WCV:
  ○ Implement value-added member engagement programs or small incentives to encourage the completion of age-appropriate wellness visits and vaccinations.
  ○ Provide clinical teams with frequent "gap-to-goal" lists to prioritize scheduling for pediatric and adolescent members approaching key age milestones.
• AMR - Total:
  ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence.
  ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management.
• GSD <8 percent:
  ○ Support the use of rapid in-office screening tools to ensure immediate clinical results and data capture, reducing reliance on external laboratory follow-ups.
  ○ Expand screening opportunities during routine clinical and pharmacy interactions to create low-barrier access for members.
  ○ Utilize clinical support staff to conduct medication reviews and regimen adjustments for members trending above the 8.0 percent threshold.
• FUH – 30 Days Total and FUM – 30 Days Total:
  ○ Expand the use of telehealth for post-discharge follow-up visits to mitigate common barriers such as transportation and scheduling conflicts.
  ○ Enhance notification systems for emergency department and inpatient discharges to ensure care managers can coordinate the required seven-day follow-up window.
• SSD:
  ○ Support behavioral health providers in performing or coordinating metabolic screenings (Glucose or A1c) during routine psychiatric visits.
  ○ Improve the bidirectional sharing of laboratory results between primary care and behavioral health providers to ensure comprehensive monitoring and reduce duplicate testing.

Molina Healthcare of Wisconsin

The following results provide an overview of the performance measure validation for MHWI.

Table 59. MHWI Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
SSI demonstrated strengths in the following measures: • FUH – 30 Days Total: Leading the 75th percentile reflected a highly coordinated transition-of-care protocol. This indicates strong partnerships between inpatient psychiatric facilities and outpatient providers, ensuring members remain clinically engaged following a mental health crisis. • FUM – 30 Days Total: Performance demonstrated that a high proportion of members successfully transitioned from emergency psychiatric care to outpatient follow-up within 30 days. This

Performance Measure Validation
performance highlighted an effective care coordination model that ensures emergency interventions are linked to ongoing community-based stabilization, significantly reducing the risk of future crises or re-hospitalization. No strengths were identified for BC+; performance across all identified measures remained below the 75th percentile benchmark.
Weaknesses/Opportunities for Improvement
BC+ demonstrated opportunities for improvement in the following measures: • CIS – Combo 3: Performance reflected a failure to complete the full 10-vaccine series by the second birthday, indicating a need for more aggressive 'catch-up' scheduling and parent education. • IMA – Combo 2: Rankings below the 50th percentile signified a drop-off in adolescent immunization rates (Meningococcal, Tdap, HPV), often due to lower frequency of office visits in this age demographic. • PPC – Timeliness of Prenatal Care: Performance suggested that members are not accessing clinical care until the second or third trimester. This indicates barriers to early pregnancy identification, delayed health plan notification, or a shortage of immediate OB-GYN appointment availability. • PPC - Postpartum Care: Rankings below the 50th percentile reflected a sharp decline in clinical engagement following delivery. This gap points to a lack of support during the transition from hospital to home, often exacerbated by childcare challenges, transportation barriers, or a lack of awareness regarding the seven–84 day HEDIS® window. • AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations. • GSD <8 percent: Performance indicated that a significant portion of the diabetic population has blood glucose levels exceeding the 8.0 percent threshold. This suggests a need for more intensive medication therapy management, improved nutritional counseling, and more frequent lab monitoring to achieve stabilization. SSI demonstrated opportunities for improvement in the following measures: • AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations. • GSD <8 percent: Performance indicated that a significant portion of the diabetic population has blood glucose levels exceeding the 8.0 percent threshold. This suggests a need for more intensive medication therapy management, improved nutritional counseling, and more frequent lab monitoring to achieve stabilization. • SSD: Performance indicated a critical gap in metabolic monitoring for high-risk members on antipsychotic medications. This suggests a lack of coordination between behavioral health providers and primary care to ensure annual A1c or glucose testing. • BCE-E: Performance reflected an opportunity to increase the proportion of women aged 50–74 who had at least one screening mammogram in the past two years. Current rates below the 50th percentile indicated a gap in early detection efforts and a need to address scheduling or access barriers for diagnostic imaging.

Performance Measure Validation
• CCS: Performance indicated that a significant number of women aged 21–64 are not receiving regular cervical cytology (Pap tests) or HPV testing within the recommended clinical timeframes. This gap highlighted a need for more robust preventative screenings and member follow-up.
Recommendations

• CIS and IMA:
  ○ Implement value-added member engagement programs or small incentives to encourage the completion of age-appropriate wellness visits and vaccinations.
  ○ Provide clinical teams with frequent "gap-to-goal" lists to prioritize scheduling for pediatric and adolescent members approaching key age milestones.
• PPC – Timeliness of Prenatal Care:
  ○ Collaborate with high-volume obstetric providers to prioritize scheduling for new members, ensuring initial prenatal visits occur shortly after enrollment.
  ○ Strengthen referral pathways with community partners and screening sites to trigger care management outreach immediately following a confirmed pregnancy.
• PPC – Postpartum Care:
  ○ Integrate postpartum follow-up scheduling into the hospital discharge process to ensure the seven–84 day visit is confirmed before the member leaves the facility.
  ○ Expand the use of telehealth for postpartum evaluations to address common social determinants of health, such as childcare needs and transportation challenges.
• AMR - Total:
  ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence.
  ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management.
• GSD <8 percent:
  ○ Support the use of rapid in-office screening tools to ensure immediate clinical results and data capture, reducing reliance on external laboratory follow-ups.
  ○ Expand screening opportunities during routine clinical and pharmacy interactions to create low-barrier access for members.
  ○ Utilize clinical support staff to conduct medication reviews and regimen adjustments for members trending above the 8.0 percent threshold.
• SSD:
  ○ Support behavioral health providers in performing or coordinating metabolic screenings (Glucose or A1c) during routine psychiatric visits.
  ○ Improve the bidirectional sharing of laboratory results between primary care and behavioral health providers to ensure comprehensive monitoring and reduce duplicate testing.
• BCE-E and CCS:
  ○ Deploy targeted mailings or digital notifications to members due for screenings based on age and clinical history.
  ○ Utilize supplemental data and administrative claims to ensure all screenings performed, including those at specialized clinics, are captured without requiring manual chart pulls.

Performance Measure Validation
○ Provide clinics with monthly member lists to identify and schedule members during routine office visits or wellness exams.

Network Health Plan

The following results provide an overview of the performance measure validation for NHP.

Table 60. NHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
BC+ demonstrated strengths in the following measures: • LSC: Achieving above the 75th percentile signified a robust POC testing culture. This reflects successful provider education and a highly effective reminder system that ensures children are screened for lead exposure by their second birthday. • CBP: Performance above the 75th percentile reflected effective hypertension management and accurate clinical documentation. SSI demonstrated strengths in the following measures: • GSD <8 percent: Exceeding the 75th percentile confirmed that most diabetic members are maintaining blood glucose levels within a safe, stable range. This suggests that providers are successfully adjusting treatment plans and that members have reliable access to necessary medications and supplies. High performance in this measure indicates a seamless flow of data between external laboratories, provider EHRs, and the health plan, ensuring that nearly all successful screenings are captured and reported accurately • FUM – 30 Days Total: Performance demonstrated that a high proportion of members successfully transitioned from emergency psychiatric care to outpatient follow-up within 30 days. This performance highlighted an effective care coordination model that ensures emergency interventions are linked to ongoing community-based stabilization, significantly reducing the risk of future crises or re-hospitalization.
Weaknesses/Opportunities for Improvement
BC+ demonstrated opportunities for improvement in the following measures: • CIS – Combo 3: Performance reflected a failure to complete the full 10-vaccine series by the second birthday, indicating a need for more aggressive 'catch-up' scheduling and parent education. • IMA – Combo 2: Rankings below the 50th percentile signified a drop-off in adolescent immunization rates (Meningococcal, Tdap, HPV), often due to lower frequency of office visits in this age demographic. • WCV – Total: Low percentile ranking suggested a decline in annual well-child engagement, potentially driven by fragmented care coordination or barriers to physical office visits. • AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations. • GSD <8 percent: Performance indicated that a significant portion of the diabetic population has blood glucose levels exceeding the 8.0 percent threshold. This suggests a need for more intensive

Performance Measure Validation
medication therapy management, improved nutritional counseling, and more frequent lab monitoring to achieve stabilization. SSI demonstrated opportunities for improvement in the following measures: • AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations. • SSD: Performance indicated a critical gap in metabolic monitoring for high-risk members on antipsychotic medications. This suggests a lack of coordination between behavioral health providers and primary care to ensure annual A1c or glucose testing.
Recommendations
• CIS, IMA, and WCV: ○ Implement value-added member engagement programs or small incentives to encourage the completion of age-appropriate wellness visits and vaccinations. ○ Provide clinical teams with frequent "gap-to-goal" lists to prioritize scheduling for pediatric and adolescent members approaching key age milestones. • AMR - Total: ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence. ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management. • GSD <8 percent: ○ Support the use of rapid in-office screening tools to ensure immediate clinical results and data capture, reducing reliance on external laboratory follow-ups. ○ Expand screening opportunities during routine clinical and pharmacy interactions to create low-barrier access for members. ○ Utilize clinical support staff to conduct medication reviews and regimen adjustments for members trending above the 8.0 percent threshold. • SSD: ○ Support behavioral health providers in performing or coordinating metabolic screenings (Glucose or A1c) during routine psychiatric visits. ○ Improve the bidirectional sharing of laboratory results between primary care and behavioral health providers to ensure comprehensive monitoring and reduce duplicate testing.

Quartz Health Solutions, Inc.

The following results provide an overview of the performance measure validation for Quartz.

Table 61. Quartz Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
BC+ demonstrated strengths in the following measure:

Performance Measure Validation
• GSD <8 percent: Performance indicated that a significant portion of the diabetic population has blood glucose levels exceeding the 8.0 percent threshold. This suggests a need for more intensive medication therapy management, improved nutritional counseling, and more frequent lab monitoring to achieve stabilization. SSI yielded no qualifying strengths, as all measures either performed below the 75th percentile or lacked a sufficient denominator for reportable status.
Weaknesses/Opportunities for Improvement
BC+ demonstrated opportunities for improvement in the following measures: • CIS – Combo 3: Performance reflected a failure to complete the full 10-vaccine series by the second birthday, indicating a need for more aggressive 'catch-up' scheduling and parent education. • LSC: Performance below the 50th percentile reflected a failure to ensure that children receive a blood lead test by their second birthday. This gap indicates a potential risk for undetected environmental lead exposure, which can lead to permanent developmental and neurological impairments. • WCV – Total: Low percentile ranking suggested a decline in annual well-child engagement, potentially driven by fragmented care coordination or barriers to physical office visits. • PPC – Timeliness of Prenatal Care: Performance suggested that members are not accessing clinical care until the second or third trimester. This indicates barriers to early pregnancy identification, delayed health plan notification, or a shortage of immediate OB-GYN appointment availability. • PPC - Postpartum Care: Rankings below the 50th percentile reflected a sharp decline in clinical engagement following delivery. This gap points to a lack of support during the transition from hospital to home, often exacerbated by childcare challenges, transportation barriers, or a lack of awareness regarding the seven–84 day HEDIS® window. • AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations. • CBP: Performance indicated that members diagnosed with hypertension are frequently remaining in a high-risk clinical state. This increases the population-level risk for acute cardiovascular events, such as stroke or myocardial infarction. Falling below the 50th percentile often reflects a 'data gap' where blood pressure readings taken during office visits are not being accurately coded (using CPT II codes) or shared with the plan, resulting in compliant members being erroneously counted as non-compliant. • FUH – 30 Days Total: Falling below the 50th percentile reflected an inability to successfully re-engage members in community-based care within 30 days of an inpatient psychiatric discharge. This gap points to a breakdown in discharge planning and inadequate post-discharge outreach. SSI demonstrated opportunities for improvement in the following measure: • CCS: Performance indicated that a significant number of women aged 21–64 are not receiving regular cervical cytology (Pap tests) or HPV testing within the recommended clinical timeframes. This gap highlighted a need for more robust preventative screenings and member follow-up.
Recommendations
• CIS and WCV: ○ Implement value-added member engagement programs or small incentives to encourage the completion of age-appropriate wellness visits and vaccinations.

- Provide clinical teams with frequent "gap-to-goal" lists to prioritize scheduling for pediatric and adolescent members approaching key age milestones.

- LSC:
  - Support the adoption of in-office capillary blood testing to allow for immediate screening and gap closure during routine pediatric visits.
  - Enhance data-sharing workflows with public health departments and community programs to capture results performed outside the primary care setting.
  - Utilize geographic and demographic data to deploy educational mailers to members in high-risk areas, emphasizing the developmental necessity of screening.
- PPC – Timeliness of Prenatal Care:
  - Collaborate with high-volume obstetric providers to prioritize scheduling for new members, ensuring initial prenatal visits occur shortly after enrollment.
  - Strengthen referral pathways with community partners and screening sites to trigger care management outreach immediately following a confirmed pregnancy.
- PPC – Postpartum Care:
  - Integrate postpartum follow-up scheduling into the hospital discharge process to ensure the seven–84 day visit is confirmed before the member leaves the facility.
  - Expand the use of telehealth for postpartum evaluations to address common social determinants of health, such as childcare needs and transportation challenges.
- AMR - Total:
  - Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence.
  - Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management.
- CBP:
  - Educate provider offices on the use of supplemental reporting codes to capture actual blood pressure values on claims, reducing the need for manual medical record reviews.
  - Train clinical staff to perform and document a second blood pressure reading if the initial result is elevated, ensuring the most accurate daily value is recorded for compliance.
  - Expand access to validated home-based blood pressure monitoring for high-risk members to capture stable readings and mitigate "white coat" effects during office visits, a phenomenon where a patient’s blood pressure readings are significantly higher in a doctor's office than they are in their daily life.
  - Utilize clinical support teams to identify members with low medication adherence and resolve specific barriers such as side effects, cost, or pharmacy access.
- FUH – 30 Days Total:
  - Expand the use of telehealth for post-discharge follow-up visits to mitigate common barriers such as transportation and scheduling conflicts.
  - Enhance notification systems for emergency department and inpatient discharges to ensure care managers can coordinate the required seven-day follow-up window.
- CCS:
  - Deploy targeted mailings or digital notifications to members due for screenings based on age and clinical history.

Performance Measure Validation
○ Utilize supplemental data and administrative claims to ensure all screenings performed, including those at specialized clinics, are captured without requiring manual chart pulls. ○ Provide clinics with monthly member lists to identify and schedule members during routine office visits or wellness exams.

Security Health Plan of Wisconsin

The following results provide an overview of the performance measure validation for SHP.

Table 62. SHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
BC+ demonstrated strengths in the following measures: • GSD <8 percent: Exceeding the 75th percentile confirmed that most diabetic members are maintaining blood glucose levels within a safe, stable range. This suggests that providers are successfully adjusting treatment plans and that members have reliable access to necessary medications and supplies. High performance in this measure indicates a seamless flow of data between external laboratories, provider EHRs, and the health plan, ensuring that nearly all successful screenings are captured and reported accurately. • CBP: Achieved performance above the 75th percentile reflected effective hypertension management and accurate clinical documentation. SSI demonstrated strengths in the following measure: • BCS-S: Performance indicated that a high proportion of eligible women aged 50–74 received timely mammograms, reflecting effective preventative outreach and a successful reduction of barriers to diagnostic imaging. Several SSI measures lacked a sufficient denominator for reportable status.
Weaknesses/Opportunities for Improvement
BC+ demonstrated opportunities for improvement in the following measures: • CIS – Combo 3: Performance reflected a failure to complete the full 10-vaccine series by the second birthday, indicating a need for more aggressive 'catch-up' scheduling and parent education. • IMA – Combo 2: Rankings below the 50th percentile signified a drop-off in adolescent immunization rates (Meningococcal, Tdap, HPV), often due to lower frequency of office visits in this age demographic. • LSC: Performance below the 50th percentile reflected a failure to ensure that children receive a blood lead test by their second birthday. This gap indicates a potential risk for undetected environmental lead exposure, which can lead to permanent developmental and neurological impairments. • WCV – Total: Low percentile ranking suggested a decline in annual well-child engagement, potentially driven by fragmented care coordination or barriers to physical office visits.

Performance Measure Validation
• FUH – 30 Days Total: Falling below the 50th percentile reflected an inability to successfully re-engage members in community-based care within 30 days of an inpatient psychiatric discharge. This gap points to a breakdown in discharge planning and inadequate post-discharge outreach. SSI demonstrated opportunities for improvement in the following measures: • CCS: Performance indicated that a significant number of women aged 21–64 are not receiving regular cervical cytology (Pap tests) or HPV testing within the recommended clinical timeframes. This gap highlighted a need for more robust preventative screenings and member follow-up.
Recommendations

• CIS, IMA, and WCV:
  ○ Implement value-added member engagement programs or small incentives to encourage the completion of age-appropriate wellness visits and vaccinations.
  ○ Provide clinical teams with frequent "gap-to-goal" lists to prioritize scheduling for pediatric and adolescent members approaching key age milestones.
• LSC:
  ○ Support the adoption of in-office capillary blood testing to allow for immediate screening and gap closure during routine pediatric visits.
  ○ Enhance data-sharing workflows with public health departments and community programs to capture results performed outside the primary care setting.
  ○ Utilize geographic and demographic data to deploy educational mailers to members in high-risk areas, emphasizing the developmental necessity of screening.
• FUH – 30 Days Total:
  ○ Expand the use of telehealth for post-discharge follow-up visits to mitigate common barriers such as transportation and scheduling conflicts.
  ○ Enhance notification systems for emergency department and inpatient discharges to ensure care managers can coordinate the required seven-day follow-up window.
• CCS:
  ○ Deploy targeted mailings or digital notifications to members due for screenings based on age and clinical history.
  ○ Utilize supplemental data and administrative claims to ensure all screenings performed, including those at specialized clinics, are captured without requiring manual chart pulls.
  ○ Provide clinics with monthly member lists to identify and schedule members during routine office visits or wellness exams.

UnitedHealthcare Community Plan

The following results provide an overview of the performance measure validation for UHC.

Table 63. UHC Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Performance Measure Validation
Strengths
BC+ demonstrated strengths in the following measures:

Performance Measure Validation

- LSC: Achieving the 75th percentile signified a robust POC testing culture. This reflects successful provider education and a highly effective reminder system that ensures children are screened for lead exposure by their second birthday.
- PPC – Timeliness of Prenatal Care: Exceeding the 75th percentile confirmed that members are successfully navigating the healthcare system early in their pregnancy. This indicates high efficiency in pregnancy notification workflows and strong provider availability for initial OB appointments.
- PPC – Postpartum Care: Performance above the 75th percentile indicated a seamless transition from delivery to community-based care. This suggests high member awareness and effective discharge planning that successfully captures the critical seven–84 day follow-up window.
- CBP: Achieved performance above the 75th percentile reflected effective hypertension management and accurate clinical documentation.

SSI demonstrated strengths in the following measure:

- GSD <8 percent: Exceeding the 75th percentile confirmed that most diabetic members are maintaining blood glucose levels within a safe, stable range. This suggests that providers are successfully adjusting treatment plans and that members have reliable access to necessary medications and supplies. High performance in this measure indicates a seamless flow of data between external laboratories, provider EHRs, and the health plan, ensuring that nearly all successful screenings are captured and reported accurately.

Weaknesses/Opportunities for Improvement

BC+ demonstrated opportunities for improvement in the following measures:

- IMA – Combo 2: Rankings below the 50th percentile signified a drop-off in adolescent immunization rates (Meningococcal, Tdap, HPV), often due to lower frequency of office visits in this age demographic.
- AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations.
- FUH – 30 Days Total: Falling below the 50th percentile reflected an inability to successfully re-engage members in community-based care within 30 days of an inpatient psychiatric discharge. This gap points to a breakdown in discharge planning and inadequate post-discharge outreach.

SSI demonstrated opportunities for improvement in the following measures:

- AMR – Total: Performance indicated an over-reliance on rescue medications and an under-utilization of long-term controller therapies among asthmatic members, increasing the risk of acute exacerbations.
- FUH – 30 Days Total: Falling below the 50th percentile reflected an inability to successfully re-engage members in community-based care within 30 days of an inpatient psychiatric discharge. This gap points to a breakdown in discharge planning and inadequate post-discharge outreach.
- SSD: Performance indicated a critical gap in metabolic monitoring for high-risk members on antipsychotic medications. This suggests a lack of coordination between behavioral health providers and primary care to ensure annual A1c or glucose testing.

Recommendations

- IMA – Combo 2:
  - Utilize bi-monthly gap reports to prioritize scheduling and outreach for members approaching their 13th birthday.

Performance Measure Validation
○ Integrate immunization screenings into all adolescent touchpoints, such as sports physicals and acute care visits, to maximize gap closure opportunities. ○ Enhance data-sharing with state immunization registries and community-based clinics to capture vaccinations administered outside the primary care setting. ○ Distribute simplified educational materials to parents and guardians emphasizing the clinical importance of completing the full multi-vaccine series on schedule. • AMR - Total: ○ Utilize pharmacy and utilization data to identify members with high rescue inhaler use and low controller medication adherence. ○ Develop and distribute simplified educational materials highlighting the different roles of maintenance versus rescue medications to improve self-management. • FUH – 30 Days Total: ○ Expand the use of telehealth for post-discharge follow-up visits to mitigate common barriers such as transportation and scheduling conflicts. ○ Enhance notification systems for emergency department and inpatient discharges to ensure care managers can coordinate the required seven-day follow-up window. • SSD: ○ Support behavioral health providers in performing or coordinating metabolic screenings (Glucose or A1c) during routine psychiatric visits. ○ Improve the bidirectional sharing of laboratory results between primary care and behavioral health providers to ensure comprehensive monitoring and reduce duplicate testing.

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. Successful implementation of these recommendations is measured by a positive shift in performance, either advancing from an opportunity for improvement to compliant status or progressing further to be recognized as a strength. The following rating scale was applied.

Table 64. 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, CY 2024, the actions taken to address the recommendations, and the degree to which the organizations addressed the recommendations.

Table 65. State-Level Progress

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
– Improve BC+ rates for: o Childhood Immunization Status – Combo 3; o Immunizations for Adolescents – Combo 2; o Lead Screening in Children; o Child and Adolescent Well-Care Visits; o Prenatal and Postpartum Care – Timeliness of Prenatal Care; o Asthma Medication Ratio (Total); o Hemoglobin A1c Control for Patients with Diabetes; o Controlling Blood Pressure; and o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – Improve Supplemental Security Income rates for: o Asthma Medication Ratio (Ages 19-64); o Follow-Up After Hospitalization for Mental Illness - 30 Days; o Follow-Up After Emergency Department Visit for Mental Illness - 30 Days; o Diabetes Screening for People with Schizophrenia or Bipolar	– The following BC+ measures demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: o Lead Screening in Children; o Prenatal and Postpartum Care – Timeliness of Prenatal Care; o Glycemic Status Assessment for Patients with Diabetes <8.0 percent; o Controlling Blood Pressure; and o Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – The following SSI measures demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength:	Low

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Disorder Who Are Using Antipsychotic Medications; ○ Breast Cancer Screening; and ○ Cervical Cancer Screening. – Improve FMCH rates for: ○ Ambulatory Care: Emergency Department Visits; ○ Outpatient Mental Health Follow-Up 7 Days After Hospitalization for Mental Illness (Ages 6 - 17); ○ Outpatient Mental Health Follow-Up 30 Days After Hospitalization for Mental Illness (Ages 6 – 17); ○ Outpatient Mental Health Follow-Up 7 Days After Emergency Department Visit for Mental Illness (Ages 6 - 17); and	○ Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total; ○ Breast Cancer Screening; and ○ Cervical Cancer Screening. – No progress was identified for the C4K recommendations, as performance remained below the 50th percentile and showed no significant improvement toward compliant status. *Ambulatory Care: Emergency Department (ED) Visits is no longer a reported measure.*	

The table below identifies the recommendations made by the EQRO in the prior review, CY 2024, the actions taken by the organizations to address the recommendations, and the degree to which each addressed the recommendations.

Table 66. MCO-Level Progress

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Anthem	Improve BC+ rates for: – Childhood Immunization Status - Combo 3; – Immunizations for Adolescents - Combo 2; – Lead Screening in Children;	– The following BC+ measures demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold	Medium

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Child and Adolescent Well-Care Visits; – Prenatal and Postpartum Care - Postpartum Care; – Asthma Medication Ratio (Total); – Hemoglobin A1c Control for Patients with Diabetes; – Controlling Blood Pressure; and – Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. Improve SSI rates for: – Asthma Medication Ratio (Ages 19-64); – Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); – Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); – Breast Cancer Screening; and – Cervical Cancer Screening.	required to be identified as a clinical strength: ○ Childhood Immunization Status - Combo 3; ○ Immunizations for Adolescents - Combo 2; ○ Lead Screening in Children; ○ Child and Adolescent Well-Care Visits; ○ Glycemic Status Assessment for Patients with Diabetes <8.0 percent; ○ Controlling Blood Pressure; and ○ Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – The following SSI measure demonstrated positive growth, surpassing the 75th percentile to achieve strength status: ○ Follow-Up After Hospitalization for Mental Illness - 30 Days (Total). – The following SSI measures demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total).	

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
CCHP	Improve BC+ rates for: – Childhood Immunization Status - Combo 3; – Immunizations for Adolescents - Combo 2; – Child and Adolescent Well-Care Visits; – Prenatal and Postpartum Care - Timeliness of Prenatal Care; – Controlling Blood Pressure; and – Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. C4K: – Ambulatory Care: Emergency Department (ED) Visits; – Outpatient Mental Health Follow-Up 7 Days After Hospitalization for Mental Illness (Ages 6 - 17); – Outpatient Mental Health Follow-Up 30 Days After Hospitalization for Mental Illness (Ages 6 – 17); – Outpatient Mental Health Follow-Up 7 Days After ED Visit for Mental Illness (Ages 6 - 17); and – Outpatient Mental Health Follow-Up 30 Days After ED Visit for Mental Illness (Ages 6 - 17).	– The following BC+ measure demonstrated positive growth, surpassing the 75th percentile to achieve strength status: ○ Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. – The following BC+ measures demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Immunizations for Adolescents - Combo 2; ○ Child and Adolescent Well-Care Visits; ○ Prenatal and Postpartum Care - Timeliness of Prenatal Care; and ○ Controlling Blood Pressure. – No progress was identified for the C4K recommendations, as performance remained below the 50th percentile and showed no significant improvement toward compliant status. *Ambulatory Care: Emergency Department (ED) Visits is no longer a reported measure.*	Medium
DHP	Improve BC+ rates for: – Childhood Immunization Status - Combo 3;	– The following BC+ measures demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While	Medium

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Lead Screening in Children; – Child and Adolescent Well-Care Visits; – Asthma Medication Ratio (Total); – Hemoglobin A1c Control for Patients with Diabetes; – Controlling Blood Pressure; and – Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total.	these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Childhood Immunization Status - Combo 3; ○ Lead Screening in Children; ○ Child and Adolescent Well-Care Visits; and ○ Controlling Blood Pressure.	
GHC-EC	Improve BC+ rates for: – Childhood Immunization Status - Combo 3; – Immunizations for Adolescents - Combo 2; – Lead Screening in Children; – Child and Adolescent Well-Care Visits; and – Controlling Blood Pressure. Improve SSI rates for: – Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); – Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); – Hemoglobin A1c Control for Patients with Diabetes; – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; and	– The following BC+ measures demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Immunizations for Adolescents - Combo 2; and ○ Controlling Blood Pressure. – The following SSI measures demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total);	Medium

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Cervical Cancer Screening.	○ Glycemic Status Assessment for Patients with Diabetes <8.0 percent; ○ Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; and ○ Cervical Cancer Screening.	
GHC-SCW	Improve BC+ rates for: – Childhood Immunization Status - Combo 3; – Lead Screening in Children; – Child and Adolescent Well-Care Visits; – Prenatal and Postpartum Care - Timeliness of Prenatal Care; – Prenatal and Postpartum Care - Postpartum Care; – Asthma Medication Ratio (Total); and – Controlling Blood Pressure.	– No progress was identified for the recommendations, as performance remained below the 50th percentile and showed no significant improvement toward compliant status.	Low
*i*Care	Improve BC+ rates for: – Childhood Immunization Status - Combo 3; – Immunizations for Adolescents - Combo 2; – Child and Adolescent Well-Care Visits; – Prenatal and Postpartum Care - Timeliness of Prenatal Care; – Prenatal and Postpartum Care - Postpartum Care;	– No progress was identified for the BC+ recommendations, as performance remained below the 50th percentile and showed no significant improvement toward compliant status. – The following SSI measure demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold	Low

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Asthma Medication Ratio (Total); – Hemoglobin A1c Control for Patients with Diabetes; and – Controlling Blood Pressure. Improve SSI rates for: – Asthma Medication Ratio (Ages 19-64); – Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); – Hemoglobin A1c Control for Patients with Diabetes; – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; – Breast Cancer Screening; and – Cervical Cancer Screening.	required to be identified as a clinical strength: ○ Glycemic Status Assessment for Patients with Diabetes <8.0 percent.	
MCHP	Improve BC+ rates for: – Childhood Immunization Status - Combo 3; – Immunizations for Adolescents - Combo 2; – Lead Screening in Children; – Child and Adolescent Well-Care Visits; – Asthma Medication Ratio (Total); – Hemoglobin A1c Control for Patients with Diabetes; – Controlling Blood Pressure; and	– The following BC+ measure demonstrated positive growth, surpassing the 75th percentile to achieve strength status: ○ Controlling Blood Pressure. – The following BC+ measure demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength:	Low

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total.	○ Immunizations for Adolescents - Combo 2.	
MHS	Improve BC+ rates for: – Childhood Immunization Status - Combo 3; – Immunizations for Adolescents - Combo 2; – Lead Screening in Children; – Child and Adolescent Well-Care Visits; – Prenatal and Postpartum Care - Postpartum Care; – Asthma Medication Ratio (Total); and – Controlling Blood Pressure. Improve SSI rates for: – Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); – Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); – Diabetes Screening for People with Schizophrenia or Bipolar; Disorder Who Are Using Antipsychotic Medications; – Breast Cancer Screening; and – Cervical Cancer Screening.	– The following BC+ measure demonstrated positive growth, surpassing the 75th percentile to achieve strength status: ○ Lead Screening in Children. – The following BC+ measure demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Prenatal and Postpartum Care - Postpartum Care; ○ Controlling Blood Pressure. – The following SSI measures demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Breast Cancer Screening; and ○ Cervical Cancer Screening.	Low
MHWI	Improve BC+ rates for: – Childhood Immunization Status - Combo 3;	– The following BC+ measure demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an	Low

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Immunizations for Adolescents - Combo 2; – Lead Screening in Children; – Child and Adolescent Well-Care Visits; – Asthma Medication Ratio (Total); and – Controlling Blood Pressure. Improve SSI rates for: – Asthma Medication Ratio (Ages 19-64); – Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); – Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; – Breast Cancer Screening; and – Cervical Cancer Screening.	immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Lead Screening in Children; ○ Child and Adolescent Well-Care Visits; and ○ Controlling Blood Pressure. – The following SSI measures demonstrated positive growth, surpassing the 75th percentile to achieve strength status: ○ Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); and ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total).	
NHP	Improve BC+ rates for: – Childhood Immunization Status - Combo 3; – Immunizations for Adolescents - Combo 2; – Lead Screening in Children; – Child and Adolescent Well-Care Visits; – Asthma Medication Ratio (Total);	– The following BC+ measures demonstrated positive growth, surpassing the 75th percentile to achieve strength status: ○ Lead Screening in Children; and ○ Controlling Blood Pressure. – The following BC+ measure demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an	Medium

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Hemoglobin A1c Control for Patients with Diabetes; and – Controlling Blood Pressure. Improve SSI rates for: – Asthma Medication Ratio (Ages 19-64); – Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; – Breast Cancer Screening; and – Cervical Cancer Screening.	immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Glycemic Status Assessment for Patients with Diabetes <8.0 percent. – The following SSI measure demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); ○ Breast Cancer Screening; and ○ Cervical Cancer Screening.	
Quartz	Improve BC+ rates for: – Childhood Immunization Status - Combo 3; – Immunizations for Adolescents - Combo 2; – Lead Screening in Children; – Child and Adolescent Well-Care Visits; – Prenatal and Postpartum Care - Timeliness of Prenatal Care; – Asthma Medication Ratio (Total);	– The following BC+ measure demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Immunizations for Adolescents - Combo 2. – No recommendations for SSI were provided in prior review as the measures lacked a sufficient	Low

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Controlling Blood Pressure; and – Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total	denominator for reportable status.	
SHP	Improve BC+ rates for: – Immunizations for Adolescents - Combo 2; – Lead Screening in Children; – Child and Adolescent Well-Care Visits; – Prenatal and Postpartum Care - Timeliness of Prenatal Care; – Prenatal and Postpartum Care - Postpartum Care; – Controlling Blood Pressure; and – Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. Improve SSI rates for: – Cervical Cancer Screening.	– The following BC+ measure demonstrated positive growth, surpassing the 75th percentile to achieve strength status: ○ Controlling Blood Pressure. – The following BC+ measure demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Prenatal and Postpartum Care - Timeliness of Prenatal Care; and ○ Prenatal and Postpartum Care - Postpartum Care. – No progress was identified for the SSI recommendations, as performance remained below the 50th percentile and showed no significant improvement toward compliant status.	Low
UHC	Improve BC+ rates for: – Childhood Immunization Status - Combo 3; – Immunizations for Adolescents - Combo 2;	– The following BC+ measure demonstrated positive growth, surpassing the 75th percentile to achieve strength status: ○ Prenatal and Postpartum Care - Postpartum Care; ○ Controlling Blood Pressure.	Low

MCO/PIHP	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Child and Adolescent Well-Care Visits; – Prenatal and Postpartum Care - Postpartum Care; – Asthma Medication Ratio (Total); – Controlling Blood Pressure; and – Follow-Up within 30 Days After Hospitalization for Mental Illness - 30 Day Total. Improve SSI rates for: – Asthma Medication Ratio (Ages 19-64); – Follow-Up After Hospitalization for Mental Illness - 30 Days (Total); – Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; – Breast Cancer Screening; and – Cervical Cancer Screening.	– The following BC+ measure demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Childhood Immunization Status - Combo 3. – The following BC+ measure demonstrated positive growth, surpassing the 50th percentile to achieve compliant status. While these rates no longer represent an immediate opportunity for improvement, they remain below the 75th percentile threshold required to be identified as a clinical strength: ○ Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total); ○ Breast Cancer Screening; and ○ Cervical Cancer Screening.	

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.

The review evaluates each organization's strengths and weaknesses related to quality, timeliness, and access to services. To streamline oversight and avoid duplication, DHS submitted an Accreditation Deeming Plan to CMS as part of its Medicaid Managed Care Quality Strategy 2025 - 2027. Under this plan, MCOs and PIHPs that hold accreditation from NCQA are deemed compliant with most federal requirements.

To ensure full compliance, MetaStar conducted an Accreditation Desk Review of elements not addressed by NCQA accreditation. The ADR confirms the organization's accreditation status and evaluates compliance with remaining federal requirements not covered by the NCQA review. This approach aligns with the CMS EQR Protocol for Medicaid Managed Care Programs.

DHS directed MetaStar to continue conducting full compliance reviews for non-accredited MCOs and PIHPs, as well as those accredited by entities not recognized under the deeming plan, following the standard three-year review cycle. As of CY 2023, all required health plans had obtained NCQA Medicaid Accreditation. See Appendix 1 for more information about the compliance review methodology.

Compliance standards are reviewed over a two-year cycle for each MCO. Year one focuses on MCO Standards, while year two includes QAPI and Grievance Systems standards. DHS may also direct additional standards to be reviewed in any year of the cycle. The table below identifies the standards evaluated in each respective year.

Table 67. 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

42 CFR § 438 (Managed Care)	42 CFR § 457 (CHIP)	Standard Name
§ 438.207	§ 457.1230(b)	Assurances of adequate capacity and services
§ 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 68. 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

CY 2025 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 CY 2025. Compliance is reported in terms of a percentage score and a compliance rating identified in the table below.

Table 69. Compliance with Standards 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

Score	Compliance Rating
≤ 59.9%	Not Met

The state-level overall compliance score was 88.8 percent, and a compliance rating of Substantially Met. The score is based on the review of the MCO Standards for all MCOs and PIHPs. 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 standard reviewed in CY 2025. See Appendix 3 for results of the QAPI and Grievance Systems Standards evaluated in prior reviews.

Table 70. State Level Compliance with Standards Results - MCO Standards

Standard	Scoring Elements	Percentage	Compliance Rating
M1: Availability of services - § 438.206 Assurances of adequate capacity and services - § 438.207	74/91	81.3%	Substantially Met
M2: Furnishing of services and timely access - § 438.206(c)(1)	88/91	96.7%	Fully Met
M3: Access and cultural considerations in services - § 438.206(c)(2)	39/39	100.0%	Fully Met
M4: Assurances of adequate capacity and services - § 438.207*	N/A	N/A	N/A
M5: Coordination and continuity of care, and confidentiality - §§ 438.208, 438.224	68/78	87.2%	Substantially Met
M6: Additional coordination and continuity of care requirements - § 438.208(c)	54/62	87.1%	Substantially Met
M7: Disenrollment: requirements and limitations - § 438.56	41/78	52.6%	Not Met
M8: Coverage and authorization of services - §§ 438.210, 440.230, 438.441 Emergency and post-stabilization services - § 438.114	111/117	94.9%	Fully Met
M9: Information requirements for all enrollees - §§ 438.100(b)(2)(i), 438.10	130/130	100.0%	Fully Met
M10: Enrollee right to receive information on available provider options - §§ 438.100(b)(2)(iii), 438.102	39/39	100.0%	Fully Met

Standard	Scoring Elements	Percentage	Compliance Rating
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)	37/52	71.2%	Partially Met
M12: Compliance with other federal and state laws - § 438.100(d)	10/13	76.9%	Partially Met
M13: Provider selection - § 438.214	143/143	100.0%	Fully Met
M14: Subcontractual relationships and delegation - § 438.230	65/65	100.0%	Fully Met
M15: Practice guidelines - § 438.236	22/39	56.4%	Not Met
M16: Health information systems - § 438.242*	N/A	N/A	N/A
Overall	**921/1037**	**88.8%**	**Substantially Met**

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

The table below presents the compliance scores for each standard reviewed in CY 2025 across the MCOs participating in the BC+ managed care programs. See Appendix 3 for results of the QAPI and Grievance Systems Standards evaluated in prior reviews.

Table 71. BC+ MCO Compliance with Standards Comparison Results – MCO Standards

Standard	CCHP**	DHP	GHC-SCW	MCHP
M1: Availability of services - § 438.206	71.4%	42.9%	85.7%	85.7%
M2: Furnishing of services and timely access - § 438.206(c)(1)	100.0%	85.7%	100.0%	100.0%
M3: Access and cultural considerations in services - § 438.206(c)(2)	100.0%	100.0%	100.0%	100.0%
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	83.3%	100.0%	83.3%	100.0%
M6: Additional coordination and continuity of care requirements - § 438.208(c)	100.0%	50.0%	50.0%	100.0%
M7: Disenrollment: requirements and limitations - § 438.56	50.0%	16.7%	50.0%	50.0%

Standard	CCHP**	DHP	GHC-SCW	MCHP
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	100.0%	100.0%	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)	75.0%	25.0%	75.0%	75.0%
M12: Compliance with other federal and state laws - § 438.100(d)	100.0%	100.0%	100.0%	100.0%
M13: Provider selection - § 438.214	100.0%	100.0%	100.0%	100.0%
M14: Subcontractual relationships and delegation - § 438.230	100.0%	100.0%	100.0%	100.0%
M15: Practice guidelines - § 438.236	66.7%	66.7%	66.7%	66.7%
M16: Health information systems - § 438.242*	N/A	N/A	N/A	N/A
Overall	**89.6%**	**80.5%**	**89.6%**	**92.2%**

*M4 and M16 are evaluated through reviews that occur separate from the compliance review.
**CCHP's results include the evaluation of BC+ and C4K.

The table below presents the compliance scores for each standard reviewed in CY 2025 across the MCOs participating in the BC+ and SSI managed care programs. See Appendix 3 for results of the QAPI and Grievance Systems Standards evaluated in prior reviews.

Table 72. BC+ and SSI MCO Compliance with Standards Comparison Results – MCO Standards

Standard	Anthem	GHC-EC	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
M1: Availability	85.7%	71.4%	85.7%	85.7%	100.0%	85.7%	85.7%	85.7%	85.7%

Standard	Anthem	GHC-EC	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
of services - § 438.206									
M2: Furnishing of services and timely access - § 438.206(c)(1)	100.0%	85.7%	85.7%	100.0%	100.0%	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%	100.0%	100.0%	100.0%	100.0%	100.0%
M4: Assurances of adequate capacity and services - § 438.207*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
M5: Coordination and continuity of care, and confidentiality - §§ 438.208, 438.224	83.3%	100.0%	83.3%	83.3%	66.7%	83.3%	100.0%	83.3%	83.3%
M6: Additional coordination and continuity of care requirements - § 438.208(c)	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	83.3%	83.3%	100.0%
M7: Disenrollment:	66.7%	33.3%	33.3%	50.0%	100.0%	50.0%	33.3%	100.0%	50.0%

Standard	Anthem	GHC-EC	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
requirements and limitations - § 438.56									
M8: Coverage and authorization of services - §§ 438.210, 440.230, 438.441 Emergency and post-stabilization services - § 438.114	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	66.7%	77.8%	100.0%
M9: Information requirements for all enrollees - §§ 438.100(b)(2)(i), 438.10	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	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%	100.0%	100.0%	100.0%	100.0%	100.0%
M11: Enrollee right to participate in decisions regarding	75.0%	75.0%	75.0%	50.0%	100.0%	50.0%	75.0%	100.0%	75.0%

Standard	Anthem	GHC-EC	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
his or her care and be free from any form of restraint - §§ 438.100(b)(2)(iv) and (v), 438.3(j)									
M12: Compliance with other federal and state laws - § 438.100(d)	100.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%
M13: Provider selection - § 438.214	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
M14: Subcontractual relationships and delegation - § 438.230	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
M15: Practice guidelines - § 438.236	100.0%	66.7%	0.0%	66.7%	66.7%	66.7%	0.0%	33.3%	66.7%
M16: Health information systems - § 438.242*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Overall	**93.8%**	**85.2%**	**81.5%**	**90.1%**	**96.3%**	**90.1%**	**84.0%**	**90.1%**	**91.4%**

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

Compliance with Standards Review - State Level Findings

The table below identifies strengths, weaknesses/opportunities for improvement, and recommendations for each standard reviewed. Strengths were given for standards that are 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 73. Compliance with Standards Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

M1: Availability of services - § 438.206
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Scoring element M1.3 required MCOs to provide a second opinion from a network provider or arrange for members to obtain one out-of-network, at no cost to the member. Three MCOs' documentation did not meet the requirement. *This scoring element was not met.* Scoring element M1.4 required MCOs to cover services out of network for members, for as long as the MCO's provider network is unable to provide them. Three MCOs' documentation did not include the requirement. *This scoring element was not met.* Scoring element M1.7 required MCOs to make the provider directory available in paper form upon request and at no cost to members. Ten MCOs' documentation did not include the requirement of the directory being provided at no cost to members. *This scoring element was not met.*
Recommendations: Amend written guidance related to second opinions to ensure members are able to obtain a second opinion from an out-of-network provider at no cost (M1.3). Revise documentation to include organizations will cover out-of-network services for members for as long as the organization's provider network is unable to provide them (M1.4). Ensure documentation includes the requirement that members may receive a paper copy of the provider directory at no cost (M1.7).

M2: Furnishing of services and timely access - § 438.206(c)(1)
Strengths: The MCOs ensured timely access to care and services by requiring network providers to meet established standards based on the urgency of members' needs. Providers maintained hours of operation consistent with those offered to commercial and Medicaid FFS members, and appointment and facility wait times were monitored to prevent discrimination. MCOs made medically necessary services available 24/7. Mechanisms were in place to ensure provider compliance, including regular monitoring and prompt corrective actions when necessary.
Weaknesses/Opportunities for Improvement: Scoring element M2.4 required MCOs to provide medically necessary high-risk prenatal care within two weeks of a member's request for an appointment, or within three weeks if the request is for a specific MCO provider, who is accepting new members. Four MCOs did not meet the requirement. *This scoring element was not met.*

M2: Furnishing of services and timely access - § 438.206(c)(1)
Recommendations: Develop and implement policies and procedures to include that members will receive high risk prenatal care within two weeks of the request for an appointment, or within three weeks if the request is for a specific MCO provider who is accepting new members (M2.4).
M3: Access and cultural considerations in services - § 438.206(c)(2)
Strengths: The MCOs actively supported the State's efforts to deliver services in a culturally competent manner to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and disabilities. The organizations incorporated the National CLAS Standards into its practices and care management services, promoted these standards among providers, and increased network diversity to meet members' linguistic and cultural needs. Members were permitted to select or change providers based on cultural or linguistic preferences, and the MCOs ensured that each member was linked to a primary care provider or clinic capable of delivering care with cultural sensitivity, understanding, and respect.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
M4: Assurances of adequate capacity and services - § 438.207
Requirements related to assurances of adequate capacity and services 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: None identified.
Weaknesses/Opportunities for Improvement: Scoring element M5.4 required MCOs share with other MCOs serving a member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated. Nine MCOs' documentation did not meet the requirement. *This scoring element was not met*.
Recommendations: Revise documentation to ensure MCOs share with other MCOs serving a member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated (M5.4).

M6: Additional coordination and continuity of care requirements - § 438.208(c)
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Scoring element M6.2 required MCOs to produce a treatment or service plan for members with special health care needs determined through assessment to need a course of treatment or regular care monitoring and follow required criteria for development and review. Six MCOs' documentation did not meet the requirement. *This scoring element was not met*. Scoring element M6.5 required MCOs to use member-level needs stratification as an input to developing care plans and providing care management to members. MCOs are required to periodically reassess whether members are assigned to the appropriate strata and continuously

M6: Additional coordination and continuity of care requirements - § 438.208(c)
monitor and enhance the MCOs' stratification method to improve the health outcomes for members. Two MCOs' documentation did not meet the requirement. *This scoring element was not met*.
Recommendations: Update documentation to ensure MCOs produce a treatment or service plan for members with special health care needs determined through assessment to need a course of treatment or regular care monitoring and follow required criteria for development and review (M6.2). Revise guidance to ensure MCOs incorporate individual member-level needs stratification as an input for developing individual care management plans, and use those plans to provide care management for members, periodically reassess whether the members are assigned to the appropriate strata, and continuously monitor and enhance the MCO's stratification method to improve the health outcomes for members (M6.5).

M7: Disenrollment: requirements and limitations - § 438.56
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Scoring element M7.2 specified that the member may voluntarily disenroll from an MCO for any reason when the member is not in the lock-in period and that voluntary disenrollment requests must come from the member, the member's family, or legal guardian. Six MCOs' documentation did not meet the requirement. *This scoring element was not met*. Scoring element M7.3 specified the reasons a member may disenroll from an MCO when in the lock-in period. Eleven MCOs' documentation did not meet the requirement. *This scoring element was not met.* Scoring element M7.4 directed MCOs to request member disenrollment through DHS's MCO Enrollment Specialist when a system-based disenrollment did not occur but should have. The requirement outlines the specific reasons for system-based disenrollment. Seven MCOs' documentation did not meet the requirement. *This scoring element was not met.* Scoring element M7.5 specified that when MCOs have identified and verified a member is no longer in the service area or has died, MCOs must provide prompt written notification and proof of the change to DHS or the appropriate entity as designated by DHS. Four MCOs' documentation did not meet the requirement. *This scoring element was not met.* Scoring element M7.6 required MCOs to direct all members with exemption requests to the Enrollment Specialist. The requirement specified member requested exemption reasons. Eleven MCOs' documentation did not meet the requirement. *This scoring element was not met.*
Recommendations: Update written guidance to include members may voluntarily disenroll from a MCO for any reason when the member is not in the lock-in period and that voluntary disenrollment requests must come from the member, the member's family, or legal guardian (M7.2). Update written guidance to include all reasons that members may disenroll from the organizations when in the lock-in period (M7.3). Revise disenrollment policies and procedures to include all system-based disenrollment reasons (M7.4).

M7: Disenrollment: requirements and limitations - § 438.56
Amend documents to specify that when the organizations have identified and verified a member has died or is no longer in the service area, the organizations must provide prompt written notification and proof of the change to DHS or the appropriate entity designated by DHS (M7.5). Update written guidance to include the MCOs are to direct all members with exemption requests to the Enrollment Specialist and include all required exemption request reasons (M7.6).
M8: Coverage and authorization of services - §§ 438.210, 440.230, 438.441 **Emergency and post-stabilization services - § 438.114**
Strengths: MCOs maintained comprehensive policies and procedures for service authorizations that complied with federal and contractual standards. The organizations ensured consistent application of review criteria and consulted with requesting providers when appropriate. Services were authorized in sufficient amount, duration, and scope to meet members' needs, and decisions were never based solely on diagnosis or condition. The MCOs provided timely written notices of decisions, including reasons and appeal rights, within required timeframes for both standard and expedited requests. Expedited decisions were made within 72 hours when necessary to protect member health, with extensions granted only under allowable circumstances. The MCOs also ensured coverage and payment for emergency and post-stabilization services regardless of provider network status and did not deny payment for qualifying emergency conditions.
Weaknesses/Opportunities for Improvement: Scoring element M8.8 required MCOs to not hold members who had an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member. Two MCOs' documentation did not meet the requirement. *This scoring element was not met.* Scoring element M8.9 required MCOs in coordination with the attending emergency physician, or the provider actually treating the member, to be responsible for determining when members are sufficiently stabilized for transfer or discharge. Three MCOs' documentation did not meet the requirement. *This scoring element was not met.*
Recommendations: Revise guidance to include that members who have an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member **(**M8.8). Amend documentation to ensure MCOs in coordination with the attending emergency physician, or the provider treating the member, are responsible for determining when members are sufficiently stabilized for transfer or discharge (M8.9).

M9: Information requirements for all enrollees - §§ 438.100(b)(2)(i), 438.10
Strengths: The MCOs consistently provided member information in a clear, accessible, and culturally appropriate manner. Written materials critical to obtaining services, including provider directories, member handbooks, and notices, were available in prevalent non-English languages and alternative formats at no cost, with conspicuous taglines explaining translation and interpretation options. MCOs ensured oral interpretation in any language and written translation in prevalent languages, as well as auxiliary aids such as TTY/TDY and ASL. Electronic materials met accessibility standards and were prominently posted online, with paper copies provided upon request within five business days. All

M9: Information requirements for all enrollees - §§ 438.100(b)(2)(i), 438.10
written materials used plain language, appropriate font size, and formats accommodating members with disabilities or limited English proficiency. Members were notified of available interpretation and auxiliary aids, and the MCOs made good faith efforts to provide timely notice of provider terminations. Additionally, the MCOs distributed member handbooks within required timeframes and maintained an up-to-date online provider directory with comprehensive details, including provider accessibility and cultural competence information.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
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 information on all available treatment options and alternatives in a manner appropriate to their condition and level of understanding. Members were given the opportunity to choose a primary care provider within the network, and designations were communicated promptly when applicable. MCOs maintained culturally appropriate care by supporting provider selection based on linguistic and cultural needs. Additionally, the MCOs did not restrict providers acting within their lawful scope of practice from advising or advocating on behalf of members regarding health status, treatment options, associated risks and benefits, and the member's right to participate in health care decisions, including the right to refuse treatment and express future preferences.
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: None identified.
Weaknesses/Opportunities for Improvement: Scoring element M11.3 required MCOs to have written restraint policies guaranteeing each member's right to be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation. Five MCOs' documentation did not meet the requirement. *This scoring element was not met.* Scoring element M11.4 required the MCO to have written policies and procedures concerning advance directives with several specific requirements. Nine MCOs' documentation did not meet the requirement. *This scoring element was not met.*
Recommendations: Develop and implement restraint policies (M11.3). Revise policies and procedures regarding advance directives to include all requirements (M11.4).

M12: Compliance with other federal and state laws - § 438.100(d)
Strengths: None identified.

M12: Compliance with other federal and state laws - § 438.100(d)
Weaknesses/Opportunities for Improvement: Scoring element M12.1 required MCOs to comply with applicable Federal and State laws for the protection of member rights. Three MCOs' documentation did not meet the requirement. *This scoring element was not met.*
Recommendations: Amend documents to include compliance with all applicable Federal and State laws for the protection of member rights (M12.1).
M13: Provider selection - § 438.214
Strengths: The MCOs maintained robust written policies and procedures for provider selection, credentialing, and recredentialing, ensuring compliance with all federal and state requirements. Initial credentialing included primary source verification of licensure, disciplinary status, and payment eligibility, while recredentialing occurred at least every three years with performance evaluations using QAPI data and member feedback. Peer review processes were in place, and the MCOs retained oversight of delegated credentialing decisions. The organizations ensured non-discrimination in provider selection, verified licensure and accreditation, prohibited contracting with excluded providers, and maintained mechanisms for suspension, termination, and appeals in accordance with federal law.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
M14: Subcontractual relationships and delegation - § 438.230
Strengths: The MCOs maintained comprehensive written policies for provider selection, credentialing, and recredentialing, ensuring compliance with federal and state standards. Initial credentialing included primary source verification of licensure, disciplinary status, and payment eligibility, while recredentialing occurred at least every three years with performance evaluations using QAPI data and member feedback. Peer review processes were implemented, oversight of delegated credentialing was retained, and mechanisms for suspension, termination, and appeals were maintained. The MCOs verified licensure and accreditation, ensured non-discrimination in provider selection, and prohibited contracting with excluded providers.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.

M15: Practice guidelines - § 438.236
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Scoring element M15.1 required MCOs to develop or adopt best practice guidelines in accordance with 42 CFR § 438.236 (b) and meet specific requirements. Two MCOs' documentation did not meet the requirement. *This scoring element was not met.* Scoring element M15.2 required decisions for utilization management, member education, coverage of services, and other areas to which the practice guidelines apply, to be consistent with the

M15: Practice guidelines - § 438.236
guidelines. Three MCOs' documentation did not meet the requirement. *This scoring element was not met* Scoring element M15.3 required MCOs to disseminate practice guidelines to all providers and, upon request, to members and potential members. Twelve MCOs' documentation did not meet the requirement. *This scoring element was not met.*
Recommendations: Update the process for developing and adopting best practice guidelines to include all requirements (M15.1). Revise written guidance for how decisions for utilization management, member education, coverage of services and other areas to which the practice guidelines apply to ensure they are consistent with the guidelines (M15.2). Ensure practice guidelines are disseminated to providers and available to members upon request (M15.3).
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

Anthem Blue Cross and Blue Shield Health Plan

The following results provide an overview of the compliance with standards review for Anthem.

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

Compliance with Standards
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 M1.7 required the MCO to make the provider directory available in paper form upon request and at no cost to the member. The MCO's submitted documents identified that members can request a paper copy of the provider directory, but did not include the requirement of the directory being provided at no cost to the member. *This scoring element was not met.* • Scoring element M5.4 required the MCO share with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated. The MCO's documentation did not demonstrate the MCO shares

Compliance with Standards

member assessment information with other MCOs to avoid duplication of services. *This scoring element was not met.*

- Scoring element M7.3 specified the reasons a member may disenroll from a MCO when in the lock-in period. The documents submitted did not include these reasons:
  - Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BadgerCare Plus enrollment has caused the member to miss the annual enrollment period;
  - If a MCO does not, because of moral or religious objections, cover the service the member seeks, the MCO must notify DHS, at the time of certification, of any services that they would not provide due to moral or religious objections;
  - If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the provider network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk;
  - The SSI MCO fails to complete the assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days; and
  - Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs.

  This scoring element was not met.
- Scoring element M7.6 required the MCO to direct all members with exemption requests to the Enrollment Specialist. The requirement specified member requested exemption reasons. The documents the organization submitted included some of the exemption reasons from enrollment, but did not include:
  - Nursing home;
  - Admission to Birth to 3 (BadgerCare Plus Only);
  - Native American;
  - Voluntary (Supplemental Security Income Medicaid Plans – Dual Eligible members with Medicaid and Medicare or Medicaid Purchase Plan members);
  - Distance;
  - Low birth weight; and
  - High risk pregnancy.

  This scoring element was not met.
- Scoring element M11.3 required MCOs to have written restraint policies guaranteeing each member's right to be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation. The MCO did not submit a written restraint policy. *This scoring element was not met.*

Recommendations

- Ensure documentation includes the requirement that members may receive a paper copy of the provider directory at no cost (M1.7).
- Revise documentation to ensure the managed care organization shares with other managed care organizations serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated (M5.4).

Compliance with Standards

• Update written guidance to include the requirement that members may disenroll from the organization when in the lock-in period for the following reasons:
  ○ Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BadgerCare Plus enrollment has caused the member to miss the annual enrollment period;
  ○ If the organization does not, because of moral or religious objections, cover the service the member seeks, the organization must notify the Wisconsin Department of Health Services, at the time of certification, of any services that they would not provide due to moral or religious objections;
  ○ If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the provider network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk;
  ○ The Supplemental Security Income managed care organization fails to complete the assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days; and
  ○ Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs (M7.3).
• Update written guidance to include the required exemption reasons for member requests to disenroll, including:
  ○ Nursing home;
  ○ Admission to Birth to 3 (BadgerCare Plus only);
  ○ Native American;
  ○ Voluntary Supplemental Security Income Medicaid Plans – dual eligible members with Medicaid and Medicare or Medicaid Purchase Plan members;
  ○ Distance;
  ○ Low birth weight; and
  ○ High risk pregnancy (M7.6).
• Develop and implement a restraint policy (M11.3).

Chorus Community Health Plan Health Plan and Care4Kids

The following results provide an overview of the compliance with standards review for CCHP.

Table 75. CCHP and C4K Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Compliance with Standards
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

Compliance with Standards

- Scoring element M1.3 required the MCO to provide a second opinion from a network provider or arrange for the member to obtain one out-of-network, at no cost to the member. The MCO's submitted documents identified that members are able to get a second medical opinion for free with an in-network provider, and a second medical opinion on recommended surgeries may be appropriate in some cases. However, documentation did not reflect the second opinion can be obtained out of network at no cost to the member. *This scoring element was not met*.
- Scoring element M1.7 required the MCO to make the provider directory available in paper form upon request and at no cost to the member. The MCO's submitted documents did not include the requirement of the directory being provided at no cost to the member. *This scoring element was not met*.
- Scoring element M5.4 required the MCO share with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated. The MCO's documentation did not demonstrate the organization shares member assessment information with other MCOs to avoid duplication of services. *This scoring element was not met*.
- Scoring element M7.3 specified the reasons a member may disenroll from a MCO when in the lock-in period. The documents submitted did not include these reasons:
  - Upon automatic reenrollment under 42 CFR § 438.56(c), the temporary loss of BC+ enrollment has caused the member to miss the annual enrollment period;
  - If a MCO does not, because of moral or religious objections, cover the service the member seeks, the MCO must notify DHS, at the time of certification, of any services that they would not provide due to moral or religious objections;
  - If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; and
  - Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs. *This scoring element was not met*.
- Scoring element M7.4 directed the MCO to request member disenrollment through DHS's MCO Enrollment Specialist when a system-based disenrollment did not occur, but should have. The requirement outlines the specific reasons for system-based disenrollment. The documents submitted did not include the system-based disenrollment reason for moving out of state or change in member circumstance. *This scoring element was not met*.
- Scoring element M7.6 ensured the MCO directs all members with exemption requests to the Enrollment Specialist. The requirement specified exemption reasons. The documents submitted did not include all required exemption requests, including:
  - Just cause;
  - Nursing home;
  - Experimental transplant;
  - Long term complex care;
  - Distance;
  - Low birth weight; and

Compliance with Standards

- High risk pregnancy.

This scoring element was not met.

- Scoring element M11.4 required the MCO to have written policies and procedures concerning advance directives, including requirements to:
  - Clarify any differences between any MCO conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives;
  - Describe the range of medical conditions or procedures affected by the conscience objection;
  - Document in the individual's medical record whether or not the individual has executed an advance directive;
  - Not discriminate in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive;
  - Ensure compliance with the requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives;
  - Provide education for staff and the community on issues concerning advance directives; and
  - Provide staff training about MCO specific policies and procedures related to advance directives.

  The advance directives policy submitted included two of the seven requirements; however, the document submitted has the organization's former name of Children's Community Health Plan and does not identify applicability to the BC+ or FCMH programs. Therefore, the advance directives policy cannot be used to validate compliance with advance directive requirements. *This scoring element was not met*.
- Scoring element M15.3 required the MCO to disseminate the guidelines to all providers and, upon request, to members and potential members. The MCO maintains a listing of clinical practice guidelines in MCO policy and within the provider Clinical & Preventative Guidelines section of the MCO's website. The clinical practice guideline listings between the MCO policy and website differ and not all of links in the policy opened. Members are to be notified of clinical practice guidelines through the member newsletter. The newsletter submitted included a link to the guidelines that did not open. *This scoring element was not met*.

Recommendations

- Amend written guidance related to second opinions to ensure members are able to obtain a second opinion from an out-of-network provider at no cost (M1.3).
- Ensure documentation includes the requirement that members may receive a paper copy of the provider directory at no cost (M1.7).
- Revise documentation to ensure the MCO shares with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated (M5.4).
- Update written guidance to include the requirement that members may disenroll from the organization when in the lock-in period for the following reasons:
  - Upon automatic reenrollment under 42 CFR § 438.56(c), the temporary loss of BC+ enrollment has caused the member to miss the annual enrollment period;

Compliance with Standards
○ If a MCO does not, because of moral or religious objections, cover the service the member seeks, the managed care organization must notify the DHS, at the time of certification, of any services they would not provide due to moral or religious objections; ○ If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; and ○ Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs (M7.3). • Revise disenrollment policies and procedures to include all system-based disenrollment reasons, including out of state moves and change in member circumstance (M7.4). • Update written guidance to include the required exemption reasons for member requests to disenroll, including: ○ Just cause; ○ Nursing home; ○ Experimental transplant; ○ Long term complex care; ○ Distance; ○ Low birth weight; and ○ High risk pregnancy (M7.6). • Revise the organization's advance directives policy and procedure to identify the updated organization name, the applicable programs, and to include all of the following advance directives requirements: ○ Clarify any differences between any organization conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives; ○ Describe the range of medical conditions or procedures affected by the conscience objection; ○ Document in the individual's medical record whether or not the individual has executed an advance directive; ○ Not discriminate in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive; ○ Ensure compliance with the requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives; ○ Provide education for staff and the community on issues concerning advance directives; and ○ Provide staff training about organization specific policies and procedures related to advance directives (M11.4).

Compliance with Standards
• Revise the organization's clinical practice guidelines policy and website to include all of the organization's clinical practice guidelines, and ensure all of the guidelines are available to providers and members (M15.3).

Dean Health Plan, Inc.

The following results provide an overview of the compliance with standards review for DHP.

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

Compliance with Standards
Strengths
• No strengths were identified in this review.
Weaknesses/Opportunities for Improvement
• Scoring element M1.3 required the MCO to provide a second opinion from a network provider or arrange for the member to obtain one out of network, at no cost to the member. The MCO's submitted documents identified that members may obtain a second opinion from an out-of-network provider with an approved prior authorization. However, documentation did not reflect the second opinion can be obtained out of network at no cost to the member. *This scoring element was not met*. • Scoring element M1.4 required the MCO to cover services out of network for the member, for as long as the MCO's provider network is unable to provide them. The MCO's submitted documents identified that members must receive prior authorization before accessing an out-of-network provider, and that new members will receive continued access to previous services when the absence of continued services would pose serious health or hospitalization risks. The documentation did not include the requirement that the MCO must adequately and timely cover necessary services out of network for members for as long as the MCO's provider network is unable to provide them. *This scoring element was not met*. • Scoring element M1.5 required the MCO to coordinate with out-of-network providers for payment and ensure the cost to the member is no greater than it would be if the services were provided within the network. The MCO's submitted documentation did not include how the MCO coordinates with out-of-network providers or that the cost to the member is no greater than it would be if the services were furnished within the network. *This scoring element was not met*. • Scoring element M1.7 required the MCO to make the provider directory available in paper form upon request and at no cost to the member. The MCO's submitted documents identified that members can request a paper copy of the provider directory, but did not include the requirement of the directory being provided at no cost to the member. *This scoring element was not met* • Scoring element M2.4 required the MCO to provide medically necessary high-risk prenatal care within two weeks of the member's request for an appointment, or within three weeks if the request is for a specific MCO provider, who is accepting new members. The MCO's documentation did not include this requirement, which is specified in the 2024 DHS-MCO contract at Article V.A.2.d. *This scoring element was not met*.

Compliance with Standards

- Scoring element M6.2 required the MCO to produce a treatment or service plan for members with special health care needs determined through assessment to need a course of treatment or regular care monitoring, and follow required criteria for development and review. The MCO's documentation did not include the requirements that the treatment plan or service plan must be developed in consultation with any providers caring for the member, and reviewed and revised when requested by the member. *This scoring element was not met*.
- Scoring element M7.2 specified that the member may voluntarily disenroll from an MCO for any reason when the member is not in the lock-in period and that voluntary disenrollment requests must come from the member, the member's family, or legal guardian. The documents submitted did not include these details. *This scoring element was not met*.
- Scoring element M7.3 specified the reasons a member may disenroll from a MCO when in the lock-in period. The documents submitted did not include these reasons:
  - Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BC+ enrollment has caused the member to miss the annual enrollment period;
  - If a MCO does not, because of moral or religious objections, cover the service the member seeks, the MCO must notify DHS, at the time of certification, of any services that they would not provide due to moral or religious objections;
  - If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the provider network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; and
  - Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs.

  This scoring element was not met.
- Scoring element M7.4 directed the MCO to request member disenrollment through the DHS MCO Enrollment Specialist when a system-based disenrollment did not occur, but should have. The requirement outlines the specific reasons for system-based disenrollment. The documents submitted did not include these requirements. *This scoring element was not met*.
- Scoring element M7.5 specified that when the MCO has identified and verified a member is no longer in the service area or has died, the MCO must provide prompt written notification and proof of the change to DHS or the appropriate entity as designated by DHS. The documents submitted did not include this information. *This scoring element was not met*.
- Scoring element M7.6 required the MCO to direct all members with exemption requests to the Enrollment Specialist. The requirement specified member requested exemption reasons. The organization submitted its BC+ manual which included several of the exemption reasons from enrollment, but did not include experimental transplant, continuity of care, or long term complex reasons. Some of the exemption reasons in the manual specified that the case head or organization was to request the exemption from enrollment, rather than the member. In addition, there was no guidance in the manual for the member to be directed to the Enrollment Specialist for these requests. *This scoring element was not met*.
- Scoring element M11.1 required MCOs to have written policies guaranteeing each member's rights, and to share those written policies with staff and affiliated providers to be considered when

Compliance with Standards

providing services to members. The MCO did not submit a written member rights policy. *This scoring element was not met*.

- Scoring element M11.3 required MCOs to have written restraint policies guaranteeing each member's right to be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation. The MCO did not submit a written restraint policy. *This scoring element was not met*.
- Scoring element M11.4 required the MCO to have written policies and procedures concerning advance directives. The policy submitted concerning advance directives did not include these requirements:
  - Clarify any differences between any MCO conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives;
  - Describe the range of medical conditions or procedures affected by the conscience objection;
  - Not discriminate in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive; and
  - Provide education to the community on issues concerning advance directives.

  This scoring element was not met.
- Scoring element M15.3 required the MCO to disseminate practice guidelines to all providers and, upon request, to members and potential members. The MCO's *Development or Adoption of Clinical Guidelines* policy identifies clinical guidelines are located in the "Providers, Policies and Guidelines" section of the MCO's website for providers. A verification of the availability of the clinical practice guidelines found two of the guidelines listed on the website, opioid use and tobacco use, did not open. In addition, the MCO's submitted documents did not include how the MCO disseminates practice guidelines to members upon request. *This scoring element was not met.*

Recommendations

- Amend written guidance to include the organization will provide for a second opinion from a network provider or arrange for the member to obtain one outside the network, at no cost to the member (M1.3).
- Revise documentation to include the organization will cover out-of-network services for members for as long as the organization's provider network is unable to provide them (M1.4).
- Ensure documentation includes the organization will coordinate with out-of-network providers for payment and ensure the cost to the member is no greater than it would be if the services were provided within the network (M1.5).
- Ensure documentation includes the requirement that members may receive a paper copy of the provider directory at no cost (M1.7).
- Develop and implement a policy and procedure to include members will receive high risk prenatal care within two weeks of the request for an appointment, or within three weeks if the request is for a specific managed care organization provider who is accepting new members (M2.4).
- Update documentation to include the requirements that the MCO must ensure the treatment or service plan is:
  - Developed in consultation with any providers caring for the member; and
  - Reviewed and revised when requested by the member (M6.2).

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- Update the organization's written guidance to include that the member may voluntarily disenroll from a MCO for any reason when the member is not in the lock-in period and that voluntary disenrollment requests must come from the member, the member's family, or legal guardian (M7.2).
- Update written guidance to include the requirement that members may disenroll from the organization when in the lock-in period for the following reasons:
  - Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BC+ enrollment has caused the member to miss the annual enrollment period;
  - If the organization does not, because of moral or religious objections, cover the service the member seeks, the organization must notify DHS, at the time of certification, of any services that they would not provide due to moral or religious objections;
  - If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; and
  - Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs (M7.3).
- Revise written guidance to include that if a MCO believes a member should have had a system-based disenrollment but has not, the MCO may request disenrollment through the Department's MCO Enrollment Specialists; and include all system-based disenrollment reasons, including:
  - Loss of BC+ and/or Medicaid SSI eligibility;
  - Out-of-service area disenrollment;
  - Medicare beneficiaries (BC+ only);
  - Inmates of a public institution;
  - Waiver programs;
  - Death;
  - Out of state moves;
  - change in member circumstances, including member moves out of service area and member death (M7.4).
- Amend documents to specify that when the organization has identified and verified a member has died or is no longer in the service area, the organization must provide prompt written notification and proof of the change to DHS or the appropriate entity designated by DHS (M7.5).
- Update written guidance to include the managed care organization is to direct all members with exemption requests to the Enrollment Specialist, and include all required exemption request reasons, including:
  - Just cause;
  - Nursing home;
  - Commercial insurance;
  - Experimental transplant;
  - Admission to Birth to 3 (BC+ only);
  - Native American;
  - Continuity of care;

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○ Long term complex care; ○ Distance; ○ Low birth weight; and ○ High risk pregnancy (M7.6). • Develop and implement a member rights policy and share the policy with staff and providers (M11.1). • Develop and implement a restraint policy (M11.3). • Revise the organization's policy regarding advance directives to include the following requirements: ○ Clarify any differences between any MCO conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives; ○ Describe the range of medical conditions or procedures affected by the conscience objection; ○ Not discriminate in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive; and ○ Provide education to the community on issues concerning advance directives (M11.4). • Ensure all clinical practice guidelines are available to providers and develop a process to provide the guidelines to members upon request (M15.3).

Group Health Cooperative of Eau Claire

The following results provide an overview of the compliance with standards review for GHC-EC.

Table 77. GHC-EC Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Compliance with Standards
Strengths
• 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 M1.3 required the MCO to provide for a second opinion from a network provider or arrange for the member to obtain one outside the network, at no cost to the member. Documentation submitted included this information, but the MCO noted the information was added to policy in May 2025, which was after the review period. *This scoring element was not met.* • Scoring element M1.4 required the MCO to adequately and timely cover necessary services out of network for members, for as long as the MCO's provider network is unable to provide them. The MCO's submitted documents included the requirement of adequately and timely covering necessary services out of network for members, but did not include the requirement of covering the services for as long as the MCO's provider network is unable to provide them. *This scoring element was not met.* • Scoring element M2.4 required the MCO to provide medically necessary high-risk prenatal care within two weeks of the member's request for an appointment, or within three weeks if the request is for a specific provider, who is accepting new members. The MCO's submitted documents

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identify that medically necessary high-risk prenatal care will be provided within two weeks of the member's request for an appointment, but does not include the requirement that high-risk prenatal care will be provided within three weeks if the request is for a specific provider, who is accepting new members. *This scoring element was not met.* • Scoring element M6.2 required the MCO to produce a treatment or service plan for members with special health care needs determined through assessment to need a course of treatment or regular care monitoring, and follow required criteria for development and review. The MCO's documentation did not include the requirement specifying the treatment or service plan must be reviewed and revised when requested by the member. *This scoring element was not met.* • Scoring element M6.5 required the MCO to use member-level needs stratification as an input to developing care plans and providing care management to members. The MCO is required to periodically reassess whether the members are assigned to the appropriate strata and continuously monitor and enhance the MCO's stratification method to improve the health outcomes for members. The MCO's documentation did not include the requirement for the monitoring and enhancement of the MCO's stratification methods to improve health outcomes for members. *This scoring element was not met.* • Scoring element M7.2 specified a member may voluntarily disenroll from a MCO for any reason when the member is not in the lock-in period, and that voluntary disenrollment requests must come from the member, the member's family, or legal guardian. The MCO's disenrollment policy does not include this disenrollment requirement. *This scoring element was not met.* • Scoring element M7.3 specified the reasons a member may disenroll from a MCO when in the lock-in period. The documents submitted did not include these reasons: ○ Upon automatic reenrollment under 42 CFR § 438.56(c), the temporary loss of BC+ enrollment has caused the member to miss the annual enrollment period; ○ If a MCO does not, because of moral or religious objections, cover the service the member seeks, the MCO must notify DHS, at the time of certification, of any services that they would not provide due to moral or religious objections; and ○ The SSI MCO fails to complete the assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days. *This scoring element was not met.* • Scoring element M7.4 directed the MCO to request member disenrollment through DHS's MCO Enrollment Specialist when a system-based disenrollment did not occur, but should have. The requirement outlines the specific reasons for system-based disenrollment. The documents submitted did not include the system-based disenrollment reason for death or moving out of state. *This scoring element was not met.* • Scoring element M7.6 ensured the MCO directs all members with exemption requests to the Enrollment Specialist. The requirement specified exemption reasons. The documents submitted did not include all required exemption requests, including: ○ Just cause; ○ Nursing home; ○ Experimental transplant;

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- Voluntary SSI Medicaid Plans – Dual Eligible Members with Medicaid and Medicare or MAPP members;
- Long term complex care;
- Distance;
- Low birth weight; and
- High risk pregnancy.

This scoring element was not met.

- Scoring element M11.4 required the MCO to have written policies and procedures concerning advance directives, including the requirement the MCO must provide staff training about MCO advance directives policies and procedures. The advance directives staff training requirement was not found in MCO documentation. *This scoring element was not met.*
- Scoring element M12.1 required the MCO to comply with applicable Federal and State laws for the protection of member rights. The MCO's member rights and responsibilities policy included this requirement; however, this information was added to the policy in May 2025, which was after the review period. *This scoring element was not met.*
- Scoring element M15.3 required the MCO to disseminate practice guidelines to all providers and, upon request, to members and potential members. The MCO maintains a listing of clinical practice guidelines in MCO policy and within the Health and Wellness Programs section and Quality Care and Patient Safety section of the MCO's website. The clinical practice guideline listings between the MCO policy and website differ. Both provider and member lists provide the source of the guidelines, but do not provide links to access the practice guidelines. *This scoring element was not met.*

Recommendations

- Update policies and procedures to include the organization will provide for a second opinion from a network provider or arrange for the member to obtain one outside the network, at no cost to the member (M1.3).
- Revise documentation to include the organization will cover out of network services for members for as long as the organization's provider network is unable to provide them (M1.4).
- Ensure documentation includes members will receive high risk prenatal care within three weeks if the request is for a specific managed care organization provider who is accepting new members (M2.4).
- Update documentation to include the requirement that the MCO must ensure the treatment or service plan is reviewed and revised if requested by the member (M6.2).
- Update policies and procedures to include the MCO's monitoring and enhancement efforts of stratification methods for improving health outcomes for members (M6.5).
- Revise the MCO's disenrollment policy to include a member may voluntarily disenroll from a MCO for any reason when the member is not in the lock-in period, and that voluntary disenrollment requests must come from the member, the member's family, or legal guardian (M7.2).
- Update written guidance to include the requirement that members may disenroll from an organization when in the lock-in period for the following reasons:
  - Upon automatic reenrollment under 42 CFR § 438.56(c), the temporary loss of BC+ enrollment has caused the member to miss the annual enrollment period;

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○ If a MCO does not, because of moral or religious objections, cover the service the member seeks, the managed care organization must notify DHS, at the time of certification, of any services they would not provide due to moral or religious objections; and ○ The SSI MCO fails to complete the assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days (M7.3). • Amend disenrollment policies and procedures to include all system-based disenrollment reasons, including death and when a member moves out of state (M7.4). • Update written guidance to include the required exemption reasons for member requests to disenroll, including: ○ Just cause; ○ Nursing home; ○ Experimental transplant; ○ Voluntary Supplemental Security Income Medicaid Plans – Dual Eligible Members with Medicaid and Medicare or MAPP members; ○ Long term complex care; ○ Distance; ○ Low birth weight; and ○ High risk pregnancy (M7.6). • Update the organization's advance directives policy and procedure to include staff training about the organization's specific advance directives policies and procedures (M11.4). • Amend documents to include compliance with all applicable Federal and State laws for the protection of member rights (M12.1). • Revise the organization's clinical practice guidelines policy and website to include all of the organization's clinical practice guidelines, and implement a process to ensure all of the guidelines are available to providers and members (M15.3).

Group Health Cooperative of South-Central Wisconsin

The following results provide an overview of the compliance with standards review for GHC-SCW.

Table 78. GHC-SCW Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Compliance with Standards
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

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- Scoring element M1.7 required the MCO to make the provider directory available in paper form upon request, and at no cost to the member. The MCO's submitted documents identify that members can call customer service for help in obtaining a paper copy of the provider directory, but did not include the requirement of the document being provided at no cost to the member. *This scoring element was not met*.
- Scoring element M5.4 required the MCO share with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated. The MCO's documentation did not demonstrate the MCO shares member assessment information with other MCOs to avoid duplication of services. *This scoring element was not met*.
- Scoring element M6.2 required the MCO to produce a treatment or service plan for members with special health care needs determined through assessment to need a course of treatment or regular care monitoring, and must follow required criteria for development and review. The MCO's documentation did not include the requirement specifying the plan must be reviewed and revised upon reassessment of functional need, at least every 12 months, or when requested by the member. *This scoring element was not met*.
- Scoring element M7.3 specified the reasons a member may disenroll from an MCO when in the lock-in period. The documents submitted did not include these reasons:
  - Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BadgerCare Plus enrollment has caused the member to miss the annual enrollment period; and
  - If an MCO does not, because of moral or religious objections, cover the service the member seeks. The MCO must notify DHS, at the time of certification, of any services that they would not provide due to moral or religious objections.

  This scoring element was not met.
- Scoring element M7.4 directed the MCO to request member disenrollment through DHS's MCO Enrollment Specialist when a system-based disenrollment did not occur, but should have. The requirement outlines the specific reasons for system-based disenrollment. The documents submitted did not include the system-based disenrollment reason for members moving out of state. *This scoring element was not met*.
- Scoring element M7.6 ensured the MCO directs all members with exemption requests to the Enrollment Specialist. The requirement specified exemption reasons. The documents submitted did not include all required exemption requests, including:
  - Just cause;
  - Long term complex care;
    - Distance;
  - Low birth weight; and
  - High risk pregnancy.

  This scoring element was not met.
- Scoring element M8.9 specified the MCO, in coordination with the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. The MCO's *Out of Area Care* policy identifies the organization will promptly provide or pay for needed contract services for emergency medical conditions and post-stabilization services, regardless of whether the provider that furnishes the

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service has a contract with GHC-SCW. While the policy included all required language related to emergency and post-stabilization of care, it is focused on coverage of services when members are temporarily out of the area and more than 50 miles from the nearest in-network provider. *This scoring element was met with a recommendation.* • Scoring element M11.4 required the MCO to have written policies and procedures concerning advance directives. The MCO's Advance Care Planning policy did not include the following requirements: ○ Clarify differences between any MCO conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives; ○ Describe the range of medical conditions or procedures affected by the conscience objection; ○ Ensure the provision to not discriminate against an individual based on whether the individual has executed an advance directive, is not construed as requiring the provision of care which conflicts with an advance directive; ○ Ensure compliance with the requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives; and ○ Provide education for staff and the community on issues concerning advance directives. *This scoring element was not met.* • Scoring element M15.3 required the MCO to disseminate practice guidelines to all providers and, upon request, to members and potential members. The MCO's policies and procedures noted clinical practice guidelines are identified on the organization's website for plan providers, and links are created within the electronic health record, EpicCare, homepage and on GHC-SCW's intranet homepage. However, a list of clinical practice guidelines available to providers was not located on the MCO's website. In addition, the organization identified formal documentation of a process to verify or ensure links to clinical practice guidelines has not been developed. The MCO did not demonstrate evidence of dissemination of practice guidelines to contracted providers. *This scoring element was not met.*
Recommendations
• Amend documentation to specify a paper form of the provider directory is available at no cost to members (M1.7). • Revise documentation to ensure the MCO shares with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated (M5.4). • Update documentation to include the requirement that the MCO must ensure the treatment or service plan is reviewed and revised: ○ At least every 12 months; or ○ If requested by the member (M6.2). • Update written guidance to include the requirement that members may disenroll from an organization when in the lock-in period for the following reasons: ○ Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BC+ enrollment has caused the member to miss the annual enrollment period; and ○ If a MCO does not, because of moral or religious objections, cover the service the member seeks (M7.3).

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• Update disenrollment policies and procedures to include all system-based disenrollment reasons, including when a member moves out of state (M7.4).
• Update written guidance to include the required exemption reasons for member requests to disenroll, including:
  ○ Just cause;
  ○ Long term complex care;
  ○ Distance;
  ○ Low birth weight; and
  ○ High risk pregnancy (M7.6).
• Amend documentation to ensure emergency and post-stabilization of care requirements are specified for members regardless of whether members receive care in network or out-of-network (M8.9).
• Include all requirements in the advance directives policies and procedures, specifically:
  ○ Clarify differences between any MCO conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives;
  ○ Describe the range of medical conditions or procedures affected by the conscience objection;
  ○ Ensure the provision to not discriminate against an individual based on whether the individual has executed an advance directive, is not construed as requiring the provision of care which conflicts with an advance directive;
  ○ Ensure compliance with the requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives; and
  ○ Provide education for staff and the community on issues concerning advance directives (M11.4).
• Ensure practice guidelines are disseminated to providers (M15.3).

Independent Care Health Plan

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

Table 79. *i*Care Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Compliance with Standards
Strengths
• 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 M1.7 required the MCO to make the provider directory available in paper form upon request and at no cost to the member. The MCO's submitted documents did not include the requirement of the directory being provided at no cost to the member. *This scoring element was not met.* • Scoring element M2.4 required the MCO to provide medically necessary high-risk prenatal care within two weeks of the member's request for an appointment, or within three weeks if the request is for a specific provider, who is accepting new members. The MCO's submitted

documents identify that medically necessary high-risk prenatal care will be provided within two weeks of the member's request for an appointment, but does not include the requirement that high-risk prenatal care will be provided within three weeks if the request is for a specific provider, who is accepting new members. *This scoring element was not met.*

- Scoring element M5.4 required the MCO share with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated. The MCO's documentation did not demonstrate the MCO shares member assessment information with other MCOs to avoid duplication of services. *This scoring element was not met.*
- Scoring element M6.2 required the MCO to produce a treatment or service plan for members with special health care needs determined through assessment to need a course of treatment or regular care monitoring, and follow required criteria for development and review. The MCO's documentation did not include the requirements that the treatment or service plan must be developed in consultation with any providers caring for the member, and approved in a timely manner if approval is required by the MCO. *This scoring element was not met.*
- Scoring element M6.3 required the MCO to have an appropriate care management infrastructure to serve the SSI managed care population. The MCO's documentation did not demonstrate the MCO has a sufficient number of trained care management staff to meet individual member needs. The policy and procedure submitted by the MCO was developed and implemented after the review period. *This scoring element was not met.*
- Scoring element M7.3 specified the reasons a member may disenroll from a MCO when in the lock-in period. The documents submitted did not include these reasons:
  - Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BC+ enrollment has caused the member to miss the annual enrollment period;
  - If a MCO does not, because of moral or religious objections, cover the service the member seeks, the MCO must notify DHS, at the time of certification, of any services that they would not provide due to moral or religious objections;
  - If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the provider network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk;
  - The MCO fails to complete the assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days; and
  - Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs.

  This scoring element was not met.
- Scoring element M7.4 directed the MCO to request member disenrollment through the DHS MCO Enrollment Specialist when a system-based disenrollment did not occur, but should have. The requirement outlines the specific reasons for system-based disenrollment. The documents submitted did not include system-based disenrollment requirements related to the following:
  - Medicare beneficiaries (BC+ only);
  - Out of state moves; and

- Change in member circumstance, including member moves out of the service area and member death.

This scoring element was not met.

- Scoring element M7.5 specified that when the MCO has identified and verified a member is no longer in the service area or has died, the MCO must provide prompt written notification and proof of the change to DHS or the appropriate entity as designated by DHS. The documents submitted did not include this information. *This scoring element was not met.*
- Scoring element M7.6 required the MCO to direct all members with exemption requests to the Enrollment Specialist. The requirement specified member requested exemption reasons. The documents the organization submitted included several of the exemption reasons from enrollment, but did not include that just cause requests for disenrollment must come from the member or include an experimental transplant as a reason for an exemption request. *This scoring element was not met.*
- Scoring element M8.9 required the MCO in coordination with the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge. The MCO's submitted documents did not include this information. *This scoring element was not met.*
- Scoring element M11.4 required the MCO to have written policies and procedures concerning advance directives. The policy submitted concerning advance directives did not include these requirements:
  - Clarify any differences between any MCO conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives; and
  - Describe the range of medical conditions or procedures affected by the conscience objection.

  This scoring element was not met.
- Scoring element M12.1 required the MCO to comply with applicable Federal and State laws, including those identified in 42 CFR § 438.100 that pertain to member rights. The MCO documents did not include this information. *This scoring element was not met.*
- Scoring element M15.1 required the MCO to develop or adopt best practice guidelines in accordance with 42 CFR § 438.236 (b) and meet specific requirements. The MCO's submitted documents did not include the requirements of how the organization considered the needs of its members when reviewing or adopting guidelines or how guidelines are adopted in consultation with network providers. *This scoring element was not met.*
- Scoring element M15.2 required decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply, to be consistent with the guidelines. The MCO's submitted documents referenced a contract with X-Plain to create new member education materials upon request. However, the Provider Clinical Practice Guidelines policy did not include this information or identify how member education is consistent with the guidelines. *This scoring element was not met.*
- Scoring element M15.3 required the MCO to disseminate practice guidelines to all providers and, upon request, to members and potential members. The MCO's Provider Clinical Practice Guidelines policy identifies clinical guidelines are located on the external provider website for use with providers. A verification of the availability of the clinical practice guidelines listed on the website

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confirmed all guidelines are available for providers. The MCO's policy identified internal staff have access to the guidelines on the staff website for use with members. The submitted documents identified that practice guidelines are available for public access on *i*Care's public website under 'Member Documents.' However, these guidelines are Milliman utilization guidelines which are different from the practice guidelines available to providers. *This scoring element was not met.*
Recommendations

• Ensure documentation includes the requirement that members may receive a paper copy of the provider directory at no cost (M1.7).
• Amend documentation to include members will receive high-risk prenatal care within three weeks if the request is for a specific managed care organization provider who is accepting new members (M2.4).
• Revise documentation to ensure the MCO shares with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated (M5.4).
• Update documentation to include the requirements that the MCO must ensure the treatment or service plan is:
  ○ Developed in consultation with any providers caring for the member; and
  ○ Approved in a timely manner if approval is required by the organization (M6.2).
• Ensure documentation that demonstrates the organization has an appropriate care management infrastructure to serve SSI members is developed and implemented within the required contract timeframe (M6.3).
• Update written guidance to include the requirement that members may disenroll from the organization when in the lock-in period for the following reasons:
  ○ Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BC+ enrollment has caused the member to miss the annual enrollment period;
  ○ If the organization does not, because of moral or religious objections, cover the service the member seeks, the organization must notify DHS, at the time of certification, of any services that they would not provide due to moral or religious objections;
  ○ If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk;
  ○ The SSI MCO fails to complete the assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days; and
  ○ Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs (M7.3).
• Revise written guidance to include that if a managed care organization believes a member should have had a system-based disenrollment but has not, the managed care organization may request disenrollment through the DHS MCO Enrollment Specialists; and include all system-based disenrollment reasons, including:
  ○ Medicare beneficiaries (BC+ only);

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○ Out of state moves; and ○ Change in member circumstances, including member moves out of the service area and member death (M7.4). • Amend documents to specify that when the organization has identified and verified a member has died or is no longer in the service area, the organization must provide prompt written notification and proof of the change to DHS or the appropriate entity designated by DHS (M7.5). • Update written guidance to include the managed care organization is to direct all members with exemption requests to the Enrollment Specialist, and include all required exemption request reasons, including: ○ Just cause; and ○ Experimental transplant (M7.6). • Develop written guidance to identify the MCO in coordination with the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge (M8.9). • Revise the organization's policy regarding advance directives to include the following requirements: ○ Clarify any differences between any MCO conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives; and ○ Describe the range of medical conditions or procedures affected by the conscience objection (M11.4). • Update written guidance to ensure compliance with all applicable Federal and State laws, including those that pertain to member rights (M12.1). • Update the process for developing and adopting practice guidelines to include the following requirements: ○ Consider the needs of the managed care organization members; and ○ Are adopted in consultation with network providers (M15.1). • Develop written guidance to include how member education is consistent with the practice guidelines (M15.2). • Implement a process to make the organization's clinical practice guidelines available to members upon request (M15.3).

MercyCare Health Plans

The following results provide an overview of the compliance with standards review for MCHP.

Table 80. MCHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Compliance with Standards
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.

Compliance with Standards
Weaknesses/Opportunities for Improvement

• Scoring element M1.7 required the MCO to make the provider directory available in paper form upon request and at no cost to the member. The MCO's submitted documents identified that members can request a paper copy of the provider directory, but did not include the requirement of the directory being provided at no cost to the member. *This scoring element was not met*.
• Scoring element M7.2 specified that voluntary disenrollment requests must come from the member, the member's family, or legal guardian. The documents submitted did not include this requirement. *This scoring element was not met*.
• Scoring element M7.3 specified the reasons a member may disenroll from an MCO when in the lock-in-period. The documents submitted included most of the reasons a member may disenroll from the MCO during their lock-in period, but did not include the requirement that the MCO must notify DHS, at the time of certification, of any service they would not provide due to moral or religious objections. *This scoring element was not met*.
• Scoring element M7.4 directed the MCO to request member disenrollment through DHS's MCO Enrollment Specialist when a system-based disenrollment did not occur, but should have. The specific reasons for system-based disenrollment were found in multiple MCO documents demonstrating compliance with this requirement; however, it was challenging to navigate and interpret the information due to its dispersion across various documents. *This scoring element was met with a recommendation.*
• Scoring element M7.6 specified that the MCO direct all members with exemption requests to the Enrollment Specialist for assistance. The requirement M7.6 details reasons for exemption requests. The documents submitted did not include the following required exemption reasons:
  ○ Long term complex care;
  ○ Distance;
  ○ Low birth weight; and
  ○ High risk pregnancy. *This scoring element was not met*.
• Scoring element M11.4 required the MCO to have written policies and procedures concerning advance directives. Documentation must include the requirement that the MCO provide staff training about MCO specific policies and procedures related to advance directives. The requirement was not documented in policy. *This scoring element was not met.*
• Scoring element M15.3 required the MCO to disseminate or make available practice guidelines to providers for whom the guidelines apply and, upon request, to members and potential members. MCO documentation indicates the guidelines are distributed to providers and members on MCHP's website. During the review of the resources available on the MCHP's website, the member link for the Explore Health Answers: Diabetes guideline, under 'Health and Wellness Program and Population Health Management' was not functional. *This scoring element was not met.*

Recommendations
• Ensure documentation includes the requirement that members may receive a paper copy of the provider directory at no cost (M1.7). • Update the organization's disenrollment policies and procedures to include that voluntary disenrollment requests must come from the member, the member's family, or legal guardian (M7.2).

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• Update written guidance to include that the organization will notify DHS, at the time of certification, of any service that would not be provided due to moral or religious objections (M7.3).
• Amend documentation to include all reasons for system-based disenrollments in one policy and procedure (M7.4).
• Update written guidance to include all required exemption reasons for member requests to disenroll, including:
  ○ Long term complex care;
  ○ Distance;
  ○ Low birth weight; and
  ○ High risk pregnancy (M7.6).
• Ensure documentation includes the requirement that the organization will provide staff training about policies and procedures related to advance directives (M11.4).
• Develop and implement a process to ensure clinical practice guidelines website links for members are functional, as submitted documentation identifies the organization disseminates these guidelines to members through its website (M15.3).

MHS Health Wisconsin

The following results provide an overview of the compliance with standards review for MHS.

Table 81. MHS Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Compliance with Standards
Strengths
• 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 M1.7 required the MCO to make the provider directory available in paper form upon request and at no cost to the member. The MCO's submitted documents did not include the requirement of the directory being provided at no cost to the member. *This scoring element was not met.* • Scoring element M5.4 required the MCO share with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated. The MCO's documentation did not demonstrate the MCO shares member assessment information with other MCOs to avoid duplication of services. *This scoring element was not met.* • Scoring element M7.2 specified that voluntary disenrollment requests must come from the member, the member's family, or legal guardian. The MCO's disenrollment policy and other documents submitted did not include this requirement. *This scoring element was not met.* • Scoring element M7.3 specified the reasons a member may disenroll from an MCO when in the lock-in period. The documents submitted did not include these reasons: ○ Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BC+ and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period; and,

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- The SSI MCO fails to complete the assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days.

This scoring element was not met.

- Scoring element M7.6 specified exemption reasons for members to be able to request disenrollment, including the MCO directing all members with exemption requests to the Enrollment Specialist for assistance. The documents submitted did not include these exemption reasons:
  - Commercial insurance;
  - Admission to Birth to 3 (BC+ only);
  - Native American;
  - Continuity of care;
  - Voluntary (SSI Medicaid plans – dual eligible members with Medicaid and Medicare or MAPP members);
  - Long term complex care (BC+ and SSI Medicaid Plans);
  - Distance; and
  - High risk pregnancy.

  This scoring element was not met.
- Scoring element M11.3 required the MCO to have a written restraint policy guaranteeing each member's right to be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation. The MCO submitted a member rights and responsibilities policy that includes details about restraint requirements; however, the MCO did not submit a written restraint policy as required per DHS-MCO contract. *This scoring element was not met.*
- Scoring element M11.4 required the MCO to have written policies and procedures concerning advance directives. Advanced directive policies and procedures must include the requirement that the MCO provide advanced directives education to the community. The requirement was not documented in policy. *This scoring element was not met.*
- Scoring element M15.3 required the MCO to disseminate or make available the practice guidelines to providers for whom the guidelines apply and, upon request, to members and potential members. The MCO submitted a list of the organization's clinical practice guidelines with website links. A verification of the guideline links functionality demonstrated that three did not function properly. Links for sickle cell anemia, autism, and Coronavirus Disease 2019 guidelines did not function properly; in addition, passwords or sign ins were required to access guidelines for opioid treatment and applied behavioral analysis. The MCO did not evidence the availability of all practice guidelines to contracted providers. *This scoring element was not met.*

Recommendations

- Ensure documentation includes the requirement that members may receive a paper copy of the provider directory at no cost (M1.7).
- Revise documentation to ensure the MCO shares with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated (M5.4).
- Update the organization's policy related to disenrollment to include that voluntary disenrollment requests must come from the member, the member's family, or legal guardian (M7.2).

Compliance with Standards

• Update written guidance to include that members may disenroll from an organization when in the lock-in period for the following reasons:
  ○ Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BC+ and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period; and
  ○ The MCO fails to complete the SSI assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days (M7.3).
• Update written guidance to include these exemption reasons for member requests to disenroll:
  ○ Commercial insurance;
  ○ Admission to Birth to 3 (BC+ only);
  ○ Native American;
  ○ Continuity of care;
  ○ Voluntary (SSI Medicaid plans – dual eligible members with Medicaid and Medicare or MAPP members);
  ○ Long term complex care (BC+ and SSI Medicaid Plans);
  ○ Distance; and
  ○ High risk pregnancy (M7.6).
• Develop and implement a written restraint policy (M11.3).
• Include the requirement that the organization will educate the community on issues concerning advance directives to policy (M11.4).
• Ensure all practice guidelines are available to providers (M15.3).

Molina Healthcare of Wisconsin

The following results provide an overview of the compliance with standards review for MHWI.

Table 82. MHWI Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Compliance with Standards
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 availability of accessible, culturally competent services through a network of qualified service providers.
Weaknesses/Opportunities for Improvement
• Scoring element M5.4 required the MCO share with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated. The MCO's documentation included the requirement that the MCO shares member assessment information with other MCOs to avoid duplication of services; however, the policy tracking log identified the information was added to the policy after the review period. *This scoring element was not met.*

Compliance with Standards
• Scoring element M5.6 required the MCO to ensure each member's privacy is protected during care coordination in accordance with privacy requirements. The MCO's documentation included the requirement that each member's privacy is protected during the process of care coordination; however, the policy tracking log on the document did not detail the revisions made to the document after the review period. Therefore, it was unclear if this requirement was implemented during the review period. *This scoring element was not met.* • Scoring element M15.3 required the MCO to disseminate practice guidelines to all providers and, upon request, to members and potential members. The MCO's documentation identified clinical guidelines are available to providers on the organization's website. A verification of the availability of the clinical practice guidelines listed on the MCO's website found that three guidelines; Social Anxiety Disorder, Substance Use Disorder Treatment for People with Co-Occurring Disorders from the Substance Abuse and Mental Health Services Administration (SAMHSA), and Trauma-Informed Primary Care, either did not open or did not lead to a guideline. In addition, the Cancer Treatment and Prevention guideline required a login entry to access the guideline. The MCO's policy identified practice guidelines are available to members through information in the member handbook and newsletters, with a copy to be provided upon request. The submitted member handbook identified guidelines for preventative services are available to members, which did not include all types of practice guidelines developed by the organization. *This scoring element was not met.*
Recommendations
• Ensure documentation that demonstrates the MCO shares with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated is implemented within the required contract timeframe (M5.4). • Ensure policy and procedure revisions are detailed to identify changes and verify contract requirements related to ensuring each member's privacy is protected during care coordination are implemented within the required timeframe (M5.6). • Implement a process to ensure all of the organization's clinical practice guidelines are available to providers and to members, upon request (M15.3).

Network Health Plan

The following results provide an overview of the compliance with standards review for NHP.

Table 83. NHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Compliance with Standards
Strengths
• 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 M1.7 required the MCO to make the provider directory available in paper form upon request and at no cost to the member. The MCO's submitted documents did not include the

requirement of the directory being provided at no cost to the member. *This scoring element was not met.*

- Scoring element M5.4 required the MCO share with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated. The MCO's documentation did not demonstrate the MCO shares member assessment information with other MCOs to avoid duplication of services. *This scoring element was not met.*
- Scoring element M7.2 specified that voluntary disenrollment requests must come from the member, the member's family, or legal guardian. The MCO's disenrollment policy and other documents submitted did not include this requirement. *This scoring element was not met.*
- Scoring element M7.3 specified the reasons a member may disenroll from an MCO when in the lock-in period. The documents submitted did not include these reasons:
  - Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BC+ and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period; and,
  - The SSI MCO fails to complete the assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days.

  This scoring element was not met.
- Scoring element M7.6 specified exemption reasons for members to be able to request disenrollment, including the MCO directing all members with exemption requests to the Enrollment Specialist for assistance. The documents submitted did not include these exemption reasons:
  - Commercial insurance;
  - Admission to Birth to 3 (BC+ only);
  - Native American;
  - Continuity of care;
  - Voluntary (SSI Medicaid plans – dual eligible members with Medicaid and Medicare or MAPP members);
  - Long term complex care (BC+ and SSI Medicaid Plans);
  - Distance; and
  - High risk pregnancy.

  This scoring element was not met.
- Scoring element M11.3 required the MCO to have a written restraint policy guaranteeing each member's right to be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation. The MCO submitted a member rights and responsibilities policy that includes details about restraint requirements; however, the MCO did not submit a written restraint policy as required per DHS-MCO contract. *This scoring element was not met.*
- Scoring element M11.4 required the MCO to have written policies and procedures concerning advance directives. Advanced directive policies and procedures must include the requirement that the MCO provide advanced directives education to the community. The requirement was not documented in policy. *This scoring element was not met.*
- Scoring element M15.3 required the MCO to disseminate or make available the practice guidelines to providers for whom the guidelines apply and, upon request, to members and potential

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members. The MCO submitted a list of the organization's clinical practice guidelines with website links. A verification of the guideline links functionality demonstrated that three did not function properly. Links for sickle cell anemia, autism, and Coronavirus Disease 2019 guidelines did not function properly; in addition, passwords or sign ins were required to access guidelines for opioid treatment and applied behavioral analysis. The MCO did not evidence the availability of all practice guidelines to contracted providers. *This scoring element was not met.*
Recommendations

• Ensure documentation includes the requirement that members may receive a paper copy of the provider directory at no cost (M1.7).
• Revise documentation to ensure the MCO shares with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated (M5.4).
• Update the organization's policy related to disenrollment to include that voluntary disenrollment requests must come from the member, the member's family, or legal guardian (M7.2).
• Update written guidance to include that members may disenroll from an organization when in the lock-in period for the following reasons:
  ○ Upon automatic reenrollment under 42 CFR § 438.56(c) the temporary loss of BC+ and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period; and
  ○ The MCO fails to complete the SSI assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days (M7.3).
• Update written guidance to include these exemption reasons for member requests to disenroll:
  ○ Commercial insurance;
  ○ Admission to Birth to 3 (BC+ only);
  ○ Native American;
  ○ Continuity of care;
  ○ Voluntary (Supplemental Security Income Medicaid plans – dual eligible members with Medicaid and Medicare or MAPP members);
  ○ Long term complex care (BC+ and SSI Medicaid Plans);
  ○ Distance; and
  ○ High risk pregnancy (M7.6).
• Develop and implement a written restraint policy (M11.3).
• Include the requirement that the organization will educate the community on issues concerning advance directives to policy (M11.4).
• Ensure all practice guidelines are available to providers (M15.3).

Quartz Health Solutions, Inc.

The following results provide an overview of the compliance with standards review for Quartz.

Table 84. Quartz Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Compliance with Standards
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 M1.7 required the MCO to make the provider directory available in paper form upon request and at no cost to the member. The MCO's submitted documents identified the process for creating a custom directory to be mailed to the member but did not include the requirement of the directory being provided at no cost to the member. *This scoring element was not met.* • Scoring element M6.2 required the MCO to produce a treatment or service plan for members with special health care needs determined through assessment to need a course of treatment or regular care monitoring and follow required criteria for development and review. The MCO's documentation did not include the requirement specifying the treatment or service plan must be reviewed and revised when requested by the member. *This scoring element was not met.* • Scoring element M7.2 required that members may voluntarily disenroll from an MCO for any reason when the member is not in the lock-in period, including that voluntary disenrollment requests must come from the member, the member's family, or legal guardian. The documents submitted did not include these requirements. *This scoring element was not met.* • Scoring element M7.3 specified the reasons a member may disenroll from a MCO when in the lock-in period. The documents submitted identified members may disenroll upon auto re-enrollment if loss of BC+/SSI caused the member to miss the annual enrollment period, and other reasons which include poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs. However, these reasons did not include any information that this is during the member lock-in period. These additional required lock-in period disenrollment reasons were not included in the documents submitted: ○ If a MCO does not, because of moral or religious objections, cover the service the member seeks, the MCO must notify DHS, at the time of certification, of any services that they would not provide due to moral or religious objections; ○ If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the provider network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; and ○ The SSI MCO fails to complete the assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days. *This scoring element was not met.* • Scoring element M7.4 directed the MCO to request member disenrollment through the DHS MCO Enrollment Specialist when a system-based disenrollment did not occur, but should have. The requirement outlines the specific reasons for system-based disenrollment. The documents

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submitted did not include information for the MCO to request disenrollment through the Department's MCO Enrollment Specialists for these required system-based disenrollment reasons:
  - Death;
  - Out of state moves; and
  - Change in member circumstance, including member moves out of the service area and member death.

This scoring element was not met.

- Scoring element M7.6 required the MCO to direct all members with exemption requests to the Enrollment Specialist. The requirement specified member requested exemption reasons. The documents submitted did not include that the MCO must direct all members with exemption requests to the Enrollment Specialist for assistance or these required exemption reasons from enrollment:
  - Voluntary SSI Medicaid Plans – Dual Eligible members with Medicaid, and Medicare or MAPP members;
  - Long term complex care (BC+ and SSI Medicaid Plans);
  - Distance;
  - Low birth weight; and
  - High risk pregnancy.

  Just cause and nursing home exemptions were identified in the documents submitted as involuntary disenrollment reasons, not as exemption reasons from enrollment. *This scoring element was not met.*
- Scoring element M8.7 required the MCO to not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, or MCO of the member's screening and treatment within 10 days of presentation for emergency services. The MCO's submitted documents did not include this information. *This scoring element was not met.*
- Scoring element M8.8 required the MCO to not hold a member who had an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member. The MCO's submitted documents did not include this information. *This scoring element was not met.*
- Scoring element M8.9 required the MCO in coordination with the attending emergency physician, or the provider treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge. The MCO's submitted documents did not include this information. *This scoring element was not met.*
- Scoring element M11.3 required MCOs to have written restraint policies guaranteeing each member's right to be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation. The MCO did not submit a written restraint policy. *This scoring element was not met.*
- Scoring element M15.1 required the MCO to develop or adopt best practice guidelines in accordance with 42 CFR § 438.236 (b) and meet specific requirements. The MCO's submitted documents did not include the following practice guideline requirements:
  - Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;

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- Consider the needs of the MCO members;
- Are adopted in consultation with network providers; and
- Are reviewed and updated periodically as appropriate.

This scoring element was not met.

- Scoring element M15.2 required decisions for utilization management, member education, coverage of services, and other areas to which the practice guidelines apply, to be consistent with the guidelines. The MCO's submitted documents did not include these requirements. *This scoring element was not met.*
- Scoring element M15.3 required the MCO to disseminate practice guidelines to all providers and, upon request, to members and potential members. The MCO's provider manual lists the MCO's adopted clinical practice guidelines. A verification of the availability of the clinical practice guidelines through links in the provider manual confirmed the guidelines are available to providers. However, the documents submitted did not identify how practice guidelines are available to members. *This scoring element was not met.*

Recommendations

- Ensure documentation includes the requirement that members may receive a paper copy of the provider directory at no cost (M1.7).
- Update documentation to include the requirement that the MCO must ensure the treatment or service plan is reviewed and revised if requested by the member (M6.2).
- Revise written guidance to include that members may voluntarily disenroll from a MCO for any reason when the member is not in the lock-in period, and that voluntary disenrollment requests must come from the member, the member's family, or legal guardian (M7.2).
- Update written guidance to include the requirement that members may disenroll from the organization when in the lock-in period, and to include these specified reasons:
  - If the organization does not, because of moral or religious objections, cover the service the member seeks, the organization must notify the DHS, at the time of certification, of any services that they would not provide due to moral or religious objections;
  - If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the provider network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; and
  - The SSI MCO fails to complete the assessment and care plan during the first 90 days of enrollment, and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days (M7.3).
- Revise written guidance to include all system-based disenrollment reasons and to specify that if a MCO believes a member should have had a system-based disenrollment but has not, the MCO may request disenrollment through the Department's MCO Enrollment Specialist (M7.4).
- Update written guidance with the following exemption request reasons, and include the MCO must direct all members with exemption requests to the Enrollment Specialist for assistance:
  - Voluntary SSI Medicaid Plans – Dual Eligible members with Medicaid, and Medicare or MAPP members;
  - Long term complex care (BC+ and SSI Medicaid Plans);
  - Distance;

Compliance with Standards
○ Low birth weight; and ○ High risk pregnancy (M7.6). • Develop written guidance for emergency and post stabilization of services to include: ○ The MCO may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, or MCO of the member's screening and treatment within 10 days of presentation for emergency services (M8.7); ○ A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member (M8.8); and ○ The organization in coordination with the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge (M8.9). • Develop and implement a restraint policy (M11.3). • Update the process for developing and adopting best practice guidelines to include the following requirements: ○ Are based on valid and reliable clinical evidence or a consensus of providers in the particular field; ○ Consider the needs of the managed care organization members; ○ Are adopted in consultation with network providers; and ○ Are reviewed and updated periodically as appropriate (M15.1). • Develop written guidance for how decisions for utilization management, member education, coverage of services and other areas to which the practice guidelines apply must be consistent with the guidelines (M15.2). • Implement a process to make the organization's clinical practice guidelines available to members upon request (M15.3).

Security Health Plan of Wisconsin

The following results provide an overview of the compliance with standards review for SHP.

Table 85. SHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Compliance with Standards
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 M1.7 required the MCO to make the provider directory available in paper form upon request and at no cost to the member. The MCO's submitted documents identify that

Compliance with Standards
members can request a paper copy of the provider directory, but did not include the requirement of the document being provided at no cost to the member. *This scoring element was not met.* • Scoring element M5.4 required the MCO to share with other MCOs serving the member the results of its identification and assessment of any member with special health care needs to avoid duplication of activities. The MCO's documentation did demonstrate the MCO shares member assessment information with other MCOs; however, documentation did not identify the MCO shares the information to avoid duplication of services. *This scoring element was not met.* • Scoring element M6.5 required the MCO to use member-level needs stratification as an input to developing care plans and providing care management to members. The MCO is required to periodically reassess whether the members are assigned to the appropriate strata and continuously monitor and enhance the MCO's stratification method to improve the health outcomes for members. The MCO's documentation did not include the requirement for the monitoring and enhancement of the MCO's stratification methods to improve health outcomes for members. *This scoring element was not met.* • Scoring element M8.8 required the MCO to not hold a member who had an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member. The MCO's submitted documents did not include this information. *This scoring element was not met.* • Scoring element M8.9 required the MCO in coordination with the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge. The MCO's submitted documents did not include this information. *This scoring element was not met.* • Scoring element M12.1 required MCOs to comply with applicable Federal and State laws for the protection of member rights. The MCO documents did not include this information. *This scoring element was not met.* • Scoring element M15.2 required decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply, to be consistent with the guidelines. The MCO's submitted documents did not include how decisions for utilization management and member education are consistent with the guidelines. *This scoring element was not met.* • Scoring element M15.3 required the MCO to disseminate practice guidelines to all providers and, upon request, to members and potential members. The MCO's submitted documents did not include how the MCO disseminates practice guidelines to members. *This scoring element was not met.* • Several policies and procedures included the BC+ program name in the document title, but identified in the body of the document that the policies and procedures applied to both the BC+ and SSI programs. While this approach demonstrates minimal compliance, opportunities for improvement were identified.
Recommendations
• Ensure documentation includes the requirement that members may receive a paper copy of the provider directory at no cost (M1.7). • Revise documentation to include the MCO shares assessment results to avoid duplication of services and supports by other MCOs serving the member (M5.4).

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• Update policies and procedures to include the MCO's monitoring and enhancement efforts of stratification methods for improving health outcomes for members (M6.5).
• Update written guidance for emergency and post stabilization of services to include:
  ○ A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member (M8.8); and
  ○ The organization in coordination with the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge (M8.9).
• Update documents to include compliance with all applicable Federal and State laws for the protection of member rights (M12.1).
• Update written guidance to include how decisions for utilization management and member education are consistent with the guidelines (M15.2).
• Develop and implement a process to disseminate clinical practice guidelines to members (M15.3).
• Update the titles of policies and procedures to ensure staff are aware they apply to both the BC+ and SSI lines of business.

UnitedHealthcare Community Plan

The following results provide an overview of the compliance with standards review for UHC.

Table 86. UHC Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Compliance with Standards
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 M1.4 required the MCO to cover services out of network for the member, for as long as the MCO's provider network is unable to provide them. The MCO's submitted documents included the requirement of adequately and timely covering necessary services out of network for members, but did not include the requirement of covering the services out of network for as long as the MCO's provider network is unable to provide them. *This scoring element was not met.* • Scoring element M5.4 required the MCO share with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated. The MCO's documentation included collaboration with state or community programs to prevent duplication of interventions, but did not identify the MCO shares member assessment information with other MCOs to avoid duplication of services. *This scoring element was not met.* • Scoring element M7.3 specified the reasons a member may disenroll from a MCO when in the lock-in period. The documents submitted did not include these reasons:

Compliance with Standards

- If a MCO does not, because of moral or religious objections, cover the service the member seeks, the MCO must notify DHS, at the time of certification, of any services that they would not provide due to moral or religious objections;
- If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the provider network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; and
- Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs.

This scoring element was not met.

- Scoring element M7.5 specified that when the MCO has identified and verified a member is no longer in the service area or has died, the MCO must provide prompt written notification and proof of the change to DHS or the appropriate entity as designated by DHS. The documents submitted did not include notification and proof of change in circumstance to DHS when a member no longer lives in the service area. *This scoring element was not met.*
- Scoring element M7.6 ensured the MCO directs all members with exemption requests to the Enrollment Specialist. The requirement specified member requested exemption reasons. The documents submitted included the list of exemption reasons, but did not direct members with exemption requests to the Enrollment Specialist for the following reasons:
  - Just cause;
  - Nursing home;
  - Experimental transplant;
  - Native American;
  - Voluntary SSI Medicaid Plans – Dual Eligible members with Medicaid and Medicare or MAPP members;
  - Low birth weight; and
  - High risk pregnancy.

  This scoring element was not met.
- Scoring element M11.4 required the MCO to have written policies and procedures concerning advance directives. The policy submitted concerning advance directives did not include these requirements:
  - Clarify any differences between any MCO conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives;
  - Describe the range of medical conditions or procedures affected by the conscience objection; and
  - Provide education to the community on issues concerning advance directives.

  This scoring element was not met.
- Scoring element M15.3 required the MCO to disseminate practice guidelines to all providers and, upon request, to members and potential members. Members are notified of clinical practice guidelines through the member newsletter. The MCO has a website link for clinical practice guidelines in its Review of Clinical and Preventive Guidelines policy and procedure. The link identifies clinical guidelines are located in the 'Policies and Protocols for Providers' section of the

Compliance with Standards
MCO's website. This clinical practice guideline listings between the MCO policy and website differ. *This scoring element was not met.*
Recommendations

• Amend documentation to include the organization will cover out of network services for members for as long as the organization's provider network is unable to provide them (M1.4).
• Revise documentation to ensure the MCO shares with other MCOs serving the member the results of its identification and assessment of any member with special health care needs so that those activities are not duplicated (M5.4).
• Update written guidance to include the requirement that members may disenroll from the organization when in the lock-in period for the following reasons:
  ○ If the organization does not, because of moral or religious objections, cover the service the member seeks, the organization must notify DHS, at the time of certification, of any services that they would not provide due to moral or religious objections;
  ○ If the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; and
  ○ Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs (M7.3).
• Amend documents to specify when the organization has identified and verified a member is no longer in the service area, the organization must provide prompt written notification and proof of the change to DHS or the appropriate entity designated by DHS (M7.5).
• Update written guidance to include the organization directs all members with exemption requests to the Enrollment Specialist for assistance related to the following exemption reasons:
  ○ Just cause;
  ○ Nursing home;
  ○ Experimental transplant;
  ○ Native American;
  ○ Voluntary Supplemental Security Income Medicaid Plans – Dual Eligible members with Medicaid and Medicare or MAPP members;
  ○ Low birth weight; and
  ○ High risk pregnancy (M7.6).
• Revise the organization's advance directives policy to include the following requirements:
  ○ Clarify any differences between any organization conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives;
  ○ Describe the range of medical conditions or procedures affected by the conscience objection; and
  ○ Provide education for the community on issues concerning advance directives (M11.4).
• Amend the organization's clinical practice guidelines policy and website to align all of the organization's clinical practice guidelines and implement a process to ensure all practice guidelines are available to providers and members (M15.3).

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 87. 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 table below 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.

Table 88. State-Level Progress on Prior Recommendations

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
– Implement procedures that include all state and federal requirements to deliver care to and coordinate services for all managed care organization members (M5). – Develop processes that comply with member disenrollment requirements (M7). – Ensure policies and procedures for service authorizations comply with all requirements (M8). – Adopt clinical practice guidelines that meet state and federal requirements (M15).	– The organizations ensured policies and procedures for service authorizations complied with all requirements (M8).	Low

The table below identifies the recommendations made by the EQRO in the prior review of the standards, the actions taken by the organizations to address the recommendations, and the degree to which each MCO addressed the recommendations.

Table 89. MCO-Level Progress

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Anthem	– Share member needs with other managed care organizations to prevent duplication of services (M5.4). – Ensure exemption request reasons are included in policies and procedures (M7.6). – Develop and implement a restraint policy (M11.3). – Develop and implement a process to immediately report the names of practitioners or providers who were terminated from the network due to quality issues to DHS (M13.8). – Ensure decisions for utilization management, member education, coverage of services, and other areas clinical practice guidelines apply are consistent with the clinical practice guidelines (M15.2). – Implement a process to ensure all practice guidelines are available on the organization's website (M15.3).	– The organization created a process to immediately report the names of practitioners or providers that were terminated from the network due to quality issues to DHS (M13.8). – The organization ensured decisions for utilization management, member education, coverage of services, and other areas clinical practice guidelines apply are consistent with the clinical practice guidelines (M15.2). – The organization implemented a process to ensure all practice guidelines are available on the organization's website (M15.3).	Medium
CCHP CCHP – C4K	– Update written guidance to include all member	– Written guidance was updated to include the following member	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	disenrollment requirements and limitations, specifically: ○ Voluntary disenrollment (M7.3.a); ○ System based disenrollment (M7.4.a); ○ Change in member circumstance resulting in disenrollment (M7.5); and ○ Exemption requests (M7.6.a, M7.6.b, M7.6.g.). – Provide the member and requesting provider written notice of decisions which include: ○ Reason; ○ Member's grievance and appeal rights; and ○ Denial of payment (M8.3). – Make decisions on standard service authorization requests within 14 calendar days following receipt of the request for service with a possible extension of up to 14 additional calendar days, if the organization justifies need for additional information and how the extension is in the enrollee's interest (M8.4.b). – Make decisions on expedited authorizations no later than 72 hours after receipt of the request for service, unless the organization extended the 72-hour time period by up to 14 calendar days as requested by the member, or the	disenrollment requirements and limitations: ○ System based disenrollment for loss of BC+ or Medicaid SSI eligibility (M7.4.a); ○ Change in member circumstance resulting in disenrollment (M7.5); and ○ Exemption requests related to continuity of care (M7.6g) – The MCO provided the member and provider with written notice of decisions which include: ○ Reason; ○ Member's grievance and appeal rights; and ○ Denial of payment (M8.3). – Written guidance was updated for decisions on standard service authorization requests to be made within 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the organization justifies need for additional information and how the extension is in the enrollee's interest (M8.4.b). – The organization updated policies and procedures to ensure decisions on expedited authorizations are made no later than 72 hours after receipt of the request for service, unless the organization extended the 72-hour time period by up to 14 calendar days as requested by	

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	organization justifies the need for more information (M8.5). – Develop and implement a process to ensure the organization does not prohibit a provider from advising or advocating on behalf of a member (M10.3). – Ensure policies and procedures include the organization's compliance with all applicable Federal and State laws for the protection of member rights (M12.1). – Develop and implement a process to immediately report the names of practitioners or providers the organization terminated from the network due to quality issues to DHS (M13.8). – Implement a process to ensure all practice guidelines are available upon request to members and potential members (M15.3).	the member, or the organization justifies the need for more information (M8.5). – The MCO developed and implemented a process to ensure the organization does not prohibit a provider from advising or advocating on behalf of a member (M10.3). – Written guidance was updated to include the organization's compliance with all applicable Federal and State laws for the protection of member rights (M12.1). – The MCO developed and implemented a process to immediately report the names of practitioners or providers the organization terminated from the network due to quality issues to DHS (M13.8).	
DHP	– Amend written guidance related to second opinions to ensure enrollees are able to obtain a second opinion from an in-network or out-of-network provider at no cost (M1.3). – Develop and implement a process for providing covered services out of network, for as long as the organization's provider network is unable to provide them (M1.4).	– Written guidance was updated to ensure network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees (M2.2). – Policies and procedures were updated to include the following criteria: o Coordination of services and follow up with members to ensure services provided	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Amend written guidance to ensure network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees (M2.2). – Ensure policies and procedures include the following criteria: ○ Coordination of services and follow up with members to ensure services provided best address their needs (M5.2); and ○ Share assessment results of members' needs with other MCOs to prevent duplication of services (M5.4). – Update written policies and procedures to include all member disenrollment requirements, specifically: ○ Voluntary disenrollment requests (M7.2); ○ System based disenrollment (M7.4); ○ Involuntary disenrollment (M7.3); ○ Change in member circumstance disenrollment notification to DHS (M7.5); and ○ Exemptions requests (M7.6).	best address their needs (M5.2); and ○ Share assessment results of members' needs with other MCOs to prevent duplication of services (M5.4) – The organization updated its policies and procedures to include the following emergency and post-stabilization specifications: ○ The organization may not hold the member liable for payment of subsequent screening and treatment to diagnosis or stabilize the member (M8.8); and ○ The organization must ensure the attending emergency physician or treating provider determines when the enrollee is stabilized for transfer or discharge (M8.9). – The organization created a process to immediately report the names of practitioners or providers that were terminated from the network due to quality issues to DHS (M13.8).	

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

	– Ensure policies and procedures include emergency and post-stabilization specifications, as indicated:
	  ○ The organization may not hold the member liable for payment of subsequent screening and treatment to diagnosis or stabilize the member (M8.8); and
	  ○ The organization must ensure the attending emergency physician or treating provider determines when the enrollee is stabilized for transfer or discharge (M8.9).
	– Create and implement a member rights policy (M11.1).
	– Develop and implement a restraint policy (M11.3).
	– Create a process to immediately report the names of practitioners or providers the organization terminated from the network due to quality issues to DHS (M13.8).
	– Develop and implement a process to ensure the organization disseminates practice guidelines to members and potential members (M15.3).		

GHC-EC	– Ensure responsibilities for emergency and post-stabilization of services are	– The organization's policies and procedures for emergency and post-stabilization of services	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	defined in the organization's policies and procedures (M8.6, M8.7). – Update written guidance to reflect that members are notified within 15 days after receipt or issuance of the contracted provider's termination notice (M9.8). – Ensure all required elements are included in the provider directory for all services offered (M9.10). – Develop written guidance for the MCO to submit a written request to the MCO's managed care analyst, in advance of a lock-in request of a member to one primary provider in cases of difficult case management (M10.2). – Revise the MCO's process to give the member rights policy to providers as required (M11.1). – Develop and implement a restraint policy (M11.3). – Revise the managed care organization's Advance Directives policy to include all required information (M11.4). – Implement a formal process of peer review of care delivered by providers that includes the active participation of contracted providers and documents the findings (M13.6).	were updated to include all required responsibilities (M8.6, M8.7). – Written guidance was updated to include that members are notified within 15 days after receipt or issuance of the contracted provider's termination notice (M9.8). – The provider directory was updated to include all required elements (M9.10). – The MCO developed written guidance to include the MCO will submit a written request to the MCO's managed care analyst, in advance of a lock-in request of a member to one primary provider in cases of difficult case management (M10.2). – The MCO revised its process to give the member rights policy to providers as required (M11.1). – The MCO implemented a restraint policy (M11.3). – The MCO implemented a formal process of peer review of care delivered by providers that includes the active participation of contracted providers and documentation of the findings (M13.6).	

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
GHC-SCW	– Focus efforts on developing and implementing procedures to ensure coordination of services for members with other MCOs and fee-for-service Medicaid (M5.2). – Amend decision-making documents to align timeframes for extensions of expedited service authorization decisions to comply with contract requirements (M8.5). – Develop and implement a process to ensure the organization does not prohibit a provider from advising or advocating on behalf of a member (M10.3). – Ensure practice guidelines are disseminated to providers, and upon request, to members and potential members (M15.3).	– The organization developed and implemented procedures to ensure coordination of services for members with other MCOs and fee-for-service Medicaid (M5.2). – The organization amended decision-making documents to align timeframes for extensions of expedited service authorization decisions to comply with contract requirements (M8.5). – The organization implemented a process to ensure it does not prohibit a provider from advising or advocating on behalf of a member (M10.3).	Medium
*i*Care	– Revise the provider onboarding process to include the Member Rights and Responsibilities policy in the documents given to all new providers (M11.1). – Update the Advance Directives policy to include the DHS-MCO contract requirements regarding staff training and community education (M11.4).	– The organization demonstrated sharing member rights and responsibilities with providers (M11.1). – The organization updated its Advance Directives policy to include the DHS-MCO contract requirements regarding staff training and community education (M11.4).	High
MCHP	– Ensure policies and procedures include	– Policies and procedures were updated to include coordination of services and follow up for:	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	coordination of services and follow up for: ○ Members with other MCOs; ○ Fee-for-service Medicaid; and ○ Community and social service providers (M5.2). – Focus efforts on developing and implementing procedures to ensure the results of any identification and assessment of the member's needs are shared with other MCOs serving the member to prevent duplication of those activities (M5.4). – Establish a process to ensure disenrollment policies and procedures contain all required federal and state requirements when requirements are effective. The organization should ensure: ○ The organization directs all members with disenrollment requests to the Enrollment Specialist for assistance and choice counseling (M7.1); ○ All BC+ members have the right to disenroll from the organization unless otherwise limited by a State Plan Amendment (M7.2); and	○ Members with other MCOs; ○ Fee-for-service Medicaid; and ○ Community and social service providers (M5.2). – The organization developed and implemented procedures to ensure the results of any identification and assessment of the member's needs are shared with other managed care organizations serving the member to prevent duplication of those activities (M5.4). – Written guidance was updated to identify the organization directs all members with disenrollment requests to the Enrollment Specialist for assistance and choice counseling (M7.1). – The organization amended written policies and procedures to include members may request disenrollment upon automatic reenrollment if the temporary loss of BC+ has caused the member to miss the annual enrollment period (M7.3.a.). – The organization updated policies and procedures to include all member disenrollment requirements, specifically: ○ System based disenrollment;	

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	○ Members may request disenrollment upon automatic reenrollment if the temporary loss of BC+ has caused the member to miss the annual enrollment period (M7.3.a.). – Update written policies and procedures to include all member disenrollment requirements, specifically: ○ System based disenrollment (M7.4); ○ Involuntary disenrollment (M7.4); ○ Change in member circumstance disenrollment notification to DHS (M7.4); and ○ Exemptions requests (M7.6). – Ensure policies and procedures for standard service authorization decisions include the requirement for when the member or provider requests the extension (M8.4). – Ensure policies and procedures for expedited authorization decisions include the requirement that the organization may extend the timeframe if the member requests an	○ Involuntary disenrollment; and ○ Change in member circumstance disenrollment notification to DHS (M7.4). – Written guidance was updated to ensure standard service authorization decisions include the requirement for when the member or provider requests the extension (M8.4). – The organization amended written guidance to ensure expedited authorization decisions include the requirement that the organization may extend the timeframe if the member requests the extension (M8.5). – Written guidance was updated to identify the attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for emergency services transfer or discharge (M8.9). – The organization implemented a process to ensure it complies with all Federal and State laws pertinent to the protection of all member rights (M12.1). – The organization ensured all federal and state requirements are included in policies and procedures for oversight of activities delegated to any	

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	extension (M8.5). – Update policies and procedures to include who is responsible to determine when the member is stabilized for emergency services transfer or discharge (M8.9). – Ensure the organization complies with all Federal and State laws pertinent to the protection of all member rights (M12.1). – Ensure all federal and state requirements are written into policies and procedures in a timely manner for oversight of activities delegated to any subcontractor/provider, specifically related to: ○ Confirmation of written agreements specifying the delegated activities of the subcontractor and providing for revocation of the delegation or other sanctions as needed (M14.1); ○ Evaluation of the subcontractor's ability to perform the delegated activity (M14.2); ○ Monitoring of the subcontractor's performance and ensuring formal review at least once per contract period (M14.3); and	subcontractor/provider, specifically related to: ○ Confirmation of written agreements specifying the delegated activities of the subcontractor and providing for revocation of the delegation or other sanctions as needed (M14.1); ○ Evaluation of the subcontractor's ability to perform the delegated activity (M14.2); ○ Monitoring of the subcontractor's performance and ensuring formal review at least once per contract period (M14.3); and – Identification of deficiencies and a process to take corrective action if needed (M14.4).	

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	○ Identification of deficiencies and a process to take corrective action if needed (M14.4). – Review the process used to update clinical practice guidelines on the organization's website to ensure links are available for providers and members, and are functioning properly (M15.3).		
MHS	– Implement a process to communicate members' needs with other organizations to prevent duplication of services (M5.4). – Focus efforts to assure written policies and procedures for member disenrollment include the following contract requirements: ○ Members may request disenrollment upon automatic reenrollment if the temporary loss of BC+ and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period (M7.3); ○ Loss of eligibility and participation in county case management waiver program or other managed care programs as reasons for disenrollment (M7.4);	– The organization updated written guidance to include all system-based disenrollment reasons, including loss of eligibility (M7.4). – The organization amended written policies and procedures to include contract requirements related to timeframes for standard authorization decisions and the provision of written notices (M8.3 and M8.4). – Written guidance was updated to identify the attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge (M8.9).	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	○ For any request for involuntary disenrollment, the organization must submit a disenrollment request to DHS and include evidence attesting to cause (M7.6); and ○ That exemption requests from enrollment in the organization must come from the member, the member's family, or the member's legal guardian (M7.2). – Ensure all contract required service authorization decision criteria are included in written policies and procedures (M8.3 and M8.4). – Amend written guidance to include the attending emergency physician or the provider actually treating the member is responsible to decide when the member is stable for transfer or discharge (M8.9). – Place priority on developing and implementing a written policy and procedure to ensure each member's right to be free from any form of restraint or seclusion (M11.3).		
MHWI	– Share with other MCOs serving the member, the results of any identification and assessment of the member's needs to prevent	– The organization ensured compliance with all member disenrollment requirements and limitations specifically for system-based and involuntary disenrollment (M7.4).	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	duplication of those activities (M5.4). – Ensure compliance with all member disenrollment requirements and limitations, specifically for system based and involuntary disenrollment (M7.4). – Implement a process to ensure all practice guidelines are available on the organization's website (M15.3).		
NHP	– Implement a process to communicate members' needs with other MCOs to prevent duplication of services (M5.4). – Focus efforts to assure written policies and procedures for member disenrollment include the following contract requirements: ○ Members may request disenrollment upon automatic reenrollment if the temporary loss of BC+ and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period (M7.3); ○ Loss of eligibility and participation in county case management waiver program or other managed care programs as reasons for disenrollment (M7.4);	– The organization updated written guidance to include all system-based disenrollment reasons, including loss of eligibility (M7.4). – The organization amended written policies and procedures to include contract requirements related to timeframes for standard authorization decisions and the provision of written notices (M8.3 and M8.4). – Written guidance was updated to identify the attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge (M8.9).	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	○ For any request for involuntary disenrollment, the organization must submit a disenrollment request to DHS and include evidence attesting to cause (M7.6); and ○ That exemption requests from enrollment in the organization must come from the member, the member's family, or the member's legal guardian (M7.2). – Ensure all contract required service authorization decision criteria are included in written policies and procedures (M8.3 and M8.4). – Amend written guidance to include the attending emergency physician or the provider actually treating the member is responsible to decide when the member is stable for transfer or discharge (M8.9). – Place priority on developing and implementing a written policy and procedure to ensure each member's right to be free from any form of restraint or seclusion (M11.3).		
Quartz	– Provide information to members on how to contact their designated primary care provider or primary care clinic (M5.1).	– The organization provided information to members on how to contact their designated primary care provider or primary care clinic (M5.1).	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Ensure the organization assists members in identifying a primary care provider as part of the initial screening process (M5.1). – Focus efforts on developing and implementing procedures to ensure coordination of services for members with other MCOs and fee-for-service Medicaid (M5.2). – Share member needs with other MCOs to prevent duplication of services (M5.4). – Ensure all federal and state requirements are written into policies and procedures in a timely manner for notices of decisions, specifically related to the provision of written notice of denial to the member and requesting provider, at the time of any action affecting the claim (M8.3). – Develop and implement a process to ensure the organization does not prohibit a provider from advising or advocating on behalf of a member (M10.3). – Ensure credentialing policies and procedures include information identifying the circumstances in which site visits are appropriate in the credentialing process (M13.1). – Develop a policy and procedure to verify each	– The organization ensured members are assisted in identifying a primary care provider as part of the initial screening process (M5.1). – The organization developed and implemented a policy and procedure to ensure coordination of services for members with other MCOs and fee-for-service Medicaid (M5.2). – The organization shared member needs with other MCOs to prevent duplication of services (M5.4). – The organization ensured all federal and state requirements are written into policies and procedures in a timely manner for notices of decisions, specifically related to the provision of written notice of denial to the member and requesting provider, at the time of any action affecting the claim (M8.3). – The organization developed and implemented a process to ensure the organization does not prohibit a provider from advising or advocating on behalf of a member (M10.3). – The organization revised documentation to ensure credentialing policies and procedures include information identifying the circumstances in which site visits are appropriate	

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	provider, other than an individual practitioner, is licensed and verify the accreditation status of providers if they claim accreditation (M13.9). – Focus efforts on developing or adopting best practice guidelines that are based on valid and reliable clinical evidence, consider the needs of the organization's members, are adopted in consultation with contracting health care professionals, and are reviewed and updated periodically as appropriate (M15.1). – Develop and implement a process to ensure practice guidelines are disseminated to members and potential members, upon request (M15.3).	in the credentialing process (M13.1). – The organization developed a policy and procedure to verify each provider, other than an individual practitioner, is licensed and verified the accreditation status of providers if they claim accreditation (M13.9).	
SHP	– Amend written guidance related to second opinions and use of out of network providers to apply to BC+ and Medicaid SSI enrollees (M1.3). – Update written guidance to specify the organization will cover services out of network for the enrollee, for as long as its network is unable to provide them (M1.4). – Amend written guidance for staff to clearly specify the State standards for timely access to care and services	– The organization amended written guidance related to second opinions and use of out of network providers to apply to BC+ and Medicaid SSI enrollees (M1.3). – Written guidance was updated to specify the organization will cover services out of network for enrollees, for as long as the network is unable to provide them (M1.4). – The organization amended written guidance to clearly specify the State standards for timely access to care and	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	according to the contract (M2.1). – Update written guidance related to ensuring each member has an ongoing primary source of care to apply to members of the BC+ and SSI programs (M5.1). – Amend written guidance to specify members may request disenrollment upon automatic reenrollment if temporary loss of Medicaid enrollment caused the member to miss the annual enrollment period and to specify the organization request for involuntary disenrollment must attest to cause (M7.3). – Update written guidance to specify system disenrollment language related to automatic disenrollments (M7.4), changes in member's circumstance (M7.5), and exemption requests from the member (M7.6); and to specify a member's right to be free from restraints or seclusion (M11.3). – Implement a process to ensure all practice guidelines are available via SHP's website (M15.3).	services according to the contract (M2.1). – The organization updated written guidance related to ensuring each member has an ongoing primary source of care to apply to members of the BC+ and SSI programs (M5.1). – The organization amended written policies and procedures to specify members may request disenrollment upon automatic reenrollment if temporary loss of Medicaid enrollment caused the member to miss the annual enrollment period and to specify the organization request for involuntary disenrollment must attest to cause (M7.3). – Written guidance was updated to specify system disenrollment language related to automatic disenrollments (M7.4), changes in member's circumstances (M7.5), exemption requests from the member (M7.6); and to specify a member's right to be free from restraints or seclusion (M11.3).	
UHC	– Focus efforts on developing and implementing procedures to ensure coordination of services for members with other MCOs, fee-for-service	– The organization developed and implemented procedures to ensure coordination of services for members with other MCOs, fee-for-service Medicaid, and	Medium

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	Medicaid, and between settings of care for appropriate discharge planning (M5.2). – Share member needs with other MCOs to prevent duplication of services (M5.4). – Update written guidance to include all member disenrollment requirements and limitations, specifically related to: o System based disenrollment (M7.4); o Change in member circumstances resulting in disenrollment (M7.5); and o Exemption requests (M7.6). – Amend member rights policies and procedures to identify specific member rights (M11.1). – Ensure policies and procedures include the organization's compliance with all applicable Federal and State laws for the protection of all member rights (M12.1). – Ensure decisions for utilization management, member education, coverage of services, and other areas clinical practice guidelines apply are consistent with the clinical practice guidelines (M15.2).	between setting of care for appropriate discharge planning (M5.2). – Written guidance was updated to include all member disenrollment requirements for system based disenrollments (M7.4). – The organization's member rights policy was amended to identify specific member rights (M11.1). – The organization updated its policies and procedures to include compliance with all applicable Federal and State laws for the protection of all member rights (M12.1). – Written guidance was updated to ensure decisions for utilization management, member education, coverage of services, and other areas clinical practice guidelines apply are consistent with the clinical practice guidelines (M15.2).	

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Develop and implement a process to ensure clinical practice guidelines are operational on the organization's website (M15.3).		

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 BC+ and SSI. The standards can be found in the *HMO Provider Network Adequacy Standards* issued March 2025. The document is available at the following link:

HMO Provider Network Adequacy Standards

Two regions, urban and rural, are designated for the network adequacy standards, with access criteria varying by region. The counties in Wisconsin are categorized as follows:

Urban: Brown, Dane, Eau Claire, Fond du Lac, Kenosha, La Crosse, Marathon, Milwaukee, Outagamie, Ozaukee, Racine, Rock, Sheboygan, St. Croix, Walworth, Washington, Waukesha, and Winnebago Counties based on similar population density characteristics.

Rural: Any county that is not considered urban.

The table below defines the provider specialties that make up each provider type. The additional tables identify the network adequacy standards established by DHS for BC+ and SSI.

Table 90. Provider Types

Provider Type	Provider Specialty Code - Description
Obstetrician/Gynecologist (OB/GYN)	095 – Nurse Practitioner/Nurse Midwife 212 – Nurse Midwife 316 – Family Practice 318 – General Practice 328 – OB/Gynecologists 350 – Licensed Midwife
Primary Care Provider (PCP)	092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice 318 – General Practice 322 – Internal Medicine 090 – Certified Pediatric Nurse Practitioners 092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice

Provider Type	Provider Specialty Code - Description
	318 – General Practice 322 – Internal Medicine 345 – Pediatricians 080 – Federally Qualified Health Center (HealthCheck related) 734 – Screener (HealthCheck) 735 – Screener/Case Management (HealthCheck)
Dental	271 – General Dentistry Practitioner 289 – Dental Hygienist 271 – General Dentistry Practitioner 274 – Pediatric Dentist 289 – Dental Hygienist
Mental Health and Substance Use Providers	112 – Licensed Psychologist (PhD) 117 – Psychiatric Nurse 120 – Licensed Psychotherapist 121 – Licensed Psychotherapist with SAC 122 – Alcohol & Other Drug Abuse Counselor 123 – Certified Psychotherapist with SAC 126 – Qualified Treatment Trainee 339 – Psychiatry 532 – Registered Alcohol and Drug Counselor 740 – Mental Health
Hospital	010 – Inpatient/Outpatient Hospital

Table 91. Drive Time (Minutes) and Distance (Miles)

Network Adequacy Indicator(s)	Applicable Provider Types	Applicable Regions
15 Minutes or 10 Miles	OB/GYN PCP	Urban
40 Minutes or 30 Miles	PCP	Rural
45 Minutes or 30 Miles	Dental, Mental Health and Substance Use Providers, and Hospital	Urban
45 Minutes or 30 Miles	OB/GYN	Rural
75 Minutes or 60 Miles	Mental Health and Substance Use Providers and Hospital	Rural
90 Minutes or 75 Miles	Dental	Rural

Table 92. Provider to Enrollee Ratio

Network Adequacy Indicator(s)	Applicable Provider Types	Applicable Regions
1:100	OB/GYN and PCP	Urban

Network Adequacy Indicator(s)	Applicable Provider Types	Applicable Regions
1:120	OB/GYN and PCP	Rural
1:900 Psychiatrist and Psychologist	Mental Health and Substance Use Providers	Urban
1:1100 Psychiatrist and Psychologist	Mental Health and Substance Use Providers	Rural
1:1600	Dental	Urban
1:1900	Dental	Rural

Table 93. Wait Time to Receive Services

Network Adequacy Indicator(s)	Applicable Provider Types	Applicable Regions
10 Business Days from Request	Mental Health and Substance Use Providers	Urban and Rural
15 Business Days from Request	OB/GYN, PCP, and Hospital	Urban and Rural
Routine: < 90 Days Emergent: < 24 Hours	Dental	Urban and Rural

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

Table 94. Data Sources

Network Adequacy Standard	Data Source(s)	Data Timeframes
Drive Time and Distance	Drive Time and Distance results calculated by DHS. Assessment of Network Adequacy Data, Methods, and Results by Myers and Stauffer.	January 1, 2024 – December 31, 2024
Provider to Member Ratios	Provider to Member Ratio results calculated by DHS. Assessment of Network Adequacy Data, Methods, and Results by Myers and Stauffer.	January 1, 2024 – December 31, 2024
Wait Time to Receive Services	Appointment availability/ accessibility study (secret shopper) of PCPs by Myers and Stauffer.	September 1, 2025 – October 31, 2025

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

Table 95. Additional Network Adequacy Analysis

Network Adequacy Analysis	Applicable Provider Types	Applicable Regions	Data Sources
Grievances and Appeals	See table above for Provider Types included in this analysis	Urban and Rural	Grievances and appeals filed January 1, 2024 – December 31, 2024.
Provider Directory to Provider Extract Match	See table above for Provider Types included in this analysis	Urban and Rural	Provider data extracts received from DHS for providers active on December 31, 2024. Health Plan directories accessed August 1, 2025 – September 30, 2025.
Actual Use of Care (Ghost Providers)	See table above for Provider Types included in this analysis	Urban and Rural	Provider data extracts received from DHS for providers active on December 31, 2024. Encounter data received from DHS for dates of service between January 1, 2024 – December 31, 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 CY 2025. Network adequacy was evaluated through two primary stages of review:

- Assessment of information systems underlying network adequacy monitoring; and
- Assessment of network adequacy data, method, and results.

The findings from the review are documented below. The assessment of network adequacy results includes an additional section detailing the findings from each network adequacy standard.

Assessment of Information Systems Underlying Network Adequacy Monitoring

The adequacy of the organizations' information systems to collect and report accurate data on network adequacy indicators was assessed using the MCOs' final audit reports from its NCQA accreditation. This approach aligns with CMS' protocol for avoiding duplication of audits. The NCQA audit supports system adequacy in several key ways. It validates the integrity of data submitted through platforms such as NCQA's secure Q-PASS, confirming that the organization's infrastructure can generate accurate and reliable information. MCOs must demonstrate how their systems support compliance with NCQA standards, including data capture, processing, and use for quality improvement, offering direct insight into system functionality and reliability. The audit also evaluates whether systems can support care delivery that meets NCQA's benchmarks for access, quality, and service. When deficiencies are identified, the process allows for corrective actions and resubmission, promoting continuous improvement. Additionally, credentialing and reporting capabilities are reviewed, both of which rely on robust information systems. Collectively, these elements ensure that the MCOs' systems are not only operational but also aligned with national standards for quality and performance.

The most recent FARs conducted for CY 2024 for each MCO were reviewed. The results are displayed in the table below.

Table 96. Assessment of Information Systems Underlying Network Adequacy Monitoring

Assessment of Information Systems Underlying Network Adequacy Monitoring
Information Systems Capability Assessment Review
Strengths: All MCOs' information systems were fully compliant with all NCQA defined standards for HEDIS® data and processes.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
Data Collection Procedures
Strengths: All MCOs' information systems were fully compliant with all NCQA defined standards for HEDIS® data and processes.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.

Assessment of Network Adequacy Data, Methods, and Results

The organizations' capacity to collect reliable and valid data for monitoring network adequacy, apply sound methodologies, and generate accurate results to support both organizational and state oversight was assessed. While Protocol 4 is primarily designed to guide EQRO validation of network adequacy analyses conducted by MCOs, it also applies when states choose to conduct

the analysis themselves. For two of the three network adequacy standards—distance and drive time, and member-to-provider ratio—the state used data submitted by MCOs, along with other relevant sources, to perform its own plan-level analysis. To ensure transparency and enable independent validation, the state shared both its analysis and the underlying data with MetaStar. The EQRO validated the state-generated indicators using the same standards and rigor as if they had been calculated by the MCOs, ensuring consistency with federal expectations and comparability of results. The results are presented in the tables below.

Network Adequacy Validation Results

Compliance with NAV requirements is expressed in terms of a percentage of network adequacy indicators met and validation rating, which refers to the EQRO's overall confidence that acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. The validation scores and ratings are identified in the table below.

See Appendix 1 for more information about the scoring methodology.

Table 97. Network Adequacy Validation Score

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

Findings in the tables below reflect the programs' compliance with each network adequacy standard established by DHS. As noted above, the distance and drive time, as well as member-to-provider ratio measures, were calculated by DHS using data submitted by the MCOs and other sources. These measures were then validated by MetaStar. The validation scores and ratings for each program are presented in the tables below, providing a clear summary of the state performance against the required standards.

Table 98. Statewide Network Adequacy Validation Results: Wait Time to Receive Services

Programs	Validation Score	Validation Rating
BC+ and SSI	43.6%	Low Confidence

Note: All secret shopper calls utilized BC+ as the member's program. MCOs that include SSI Care Management program utilize a similar provider networks as BC+.

Network Adequacy Validation Results: Wait Time to Receive Services

For this assessment, a secret shopper survey approach was used. Secret shopper surveys are a tool to test the accuracy of the provider directory and ensure compliance with appointment wait time standards. Individuals pose as potential patients, contact providers within an MCO's network, attempt to schedule appointments, and record the following details regarding the secret shopper call:

- **Network Directory Accuracy:** If the provider contact details, address, in-network status, and other data listed in the directory aligns with information gathered from the provider's website and/or information gathered during the call.
- **Provider Availability:** If the provider is accepting new patients and has open appointment date/time slots available.
- **Appointment Wait Times:** The earliest available appointment time offered, and in the event of appointment unavailability, if an appointment with a different provider and/or a telehealth appointment was offered.

Secret shopper activities are conducted against established network adequacy standards set by the State. The data collected from secret shopper calls are analyzed to identify areas where the MCOs' provider networks may be lacking in accessibility and to take corrective actions, such as adding more providers or addressing issues with provider directories.

Secret Shopper Methodology and Pre-call Quality Reviews

The sample size by MCO was determined proportionally. The ratio of the MCO's member count to the state member count was calculated and then applied to a value of one thousand – the total number of providers that were sample across all MCOs. Additionally, the number of providers sampled was adjusted, if applicable, to ensure a minimum of 30 providers sampled for each health plan. The providers selected were based on the primary care provider specialty codes in the MCO Provider Network Adequacy Standards received from DHS (e.g. Family Practice, General Practice, Internal Medicine, Physician Assistants, Nurse Practitioners, Pediatricians), and an active provider status in 2024 per the MCO. See the table below for the list of provider specialties categorized as PCP.

After locating a provider in the health plan directory, the data for all sampled providers was cross-checked with the provider's website, if available. If there was a discrepancy between the directory and provider website, the provider website's contact information was provided to the callers to increase the chances of obtaining an appointment with the provider. If a sampled provider was not located in the MCO online directory, all contact information for the call was

obtained from a provider website. Furthermore, if the provider's website indicated the provider does not practice in Wisconsin or a bordering state and/or provide routine, non-urgent appointments, the provider was not included in the call list. The table below summarizes the reasons for exclusion of providers.

Table 99. Statewide Provider Call List Exclusions

Exclusion Reason	Provider Count	Percentage
Number of providers sampled and researched (denominator)	1,000	100.0%
No Routine, Non-Urgent Appointments (e.g. Specialist, Hospitalist, Urgent Care)	578	57.8%
No Current, In-Person Practice Located	99	9.9%
Only Certain Populations	3	0.3%
Private Pay Only	1	0.1%
Number of providers included in the secret shopper call list	**319**	**31.9%**

Additional quality reviews were performed to determine the completeness and accuracy of the provider information in the HPN file and the MCO's online directory. The results of these reviews can be found in Appendix 4.

Secret shopper calls were performed by Myers and Stauffer. The PCPs were called to inquire about routine, in-person, non-urgent, appointments for a new adult patient, or child, if the provider was a pediatrician. Callers attempted to reach providers a maximum of three times during standard business hours.

Secret Shopper Results

The survey results were documented for each completed call using the fields and definitions set in the Secret Shopper Training Guide and caller worksheets. The data reported reflects the status of the individual provider sampled and does not account for other providers within the group/practice associated with the sampled provider unless specified otherwise.

Each call was categorized as follows:

- **Invalid Phone Number:** The phone number was disconnected, or the phone number was for a business entity other than the physician's office, practice or hospital/healthcare system.
- **Non-Responsive Provider:** A provider representative was not reached after attempting the call three separate times. This included being placed on hold and/or reaching a voicemail box. The caller was instructed to wait up to five minutes if placed on hold and told not to leave a voicemail, to preserve anonymity as a secret shopper.
- **Completed Call:** A medical office representative was reached, regardless of whether it was the sampled provider's office.

The objective of the survey was to obtain an offer for the next available appointment from the provider. If an appointment date was not offered, the caller was asked to note the reason for not being offered an appointment. Callers not receiving an appointment date were unable to schedule an appointment for the following reasons:

- **Not Accepting Patients or Insurance:** The provider is not accepting new patients, Medicaid, the specific MCO, or BC+.
    - Provider does not accept new patients under any circumstances.
    - Does not accept MCO and/or program.
    - Office representative did not give a definitive answer or did not know if the provider accepts the MCO.
- **Scope of Practice Limitations:** The provider is not scheduling routine appointments due to the nature of their practice.
    - Provider is not primary care (e.g., hospitalist or specialist).
    - Provider only sees certain populations (e.g., age-restricted).
    - Provider accepts patients with pre-existing conditions or existing families only.
- **Additional Information Needed:** The caller must register or provide medical records/labs before an appointment date is offered.
    - Personal information or additional steps required to receive appointment date.
    - Registration requirement before office will discuss provider details.
- **Provider No Longer with Group/Practice:** The provider is retired, the office is closed, or they no longer practice at the contacted location.
    - Office is not aware of the provider.
- **Invalid Phone Number:** The number was disconnected or belonged to a different business entity.

- **The Provider is on Leave:** The provider is currently on leave but may have a waitlist.
- **Non-Responsive Provider:** No representative was reached after three attempts, including being left on hold or sent to voicemail.
- **Other:** The call was ended by the representative before appointment availability could be determined.

The table below provides the secret shopper call outcomes.

Table 100. Secret Shopper Call Outcomes by MCO

MCO	Percentage of Appointments Offered from All Calls	Percentage of Appointments Offered from Completed Calls
Anthem	41.0%	43.2%
CCHP	20.6%	20.6%
DHP	29.6%	29.6%
GHC-EC	0.0%	0.0%
GHC-SCW	13.3%	13.3%
*i*Care	23.8%	26.3%
MCHP	33.3%	36.4%
MHS	30.8%	36.4%
MHWI	18.2%	18.2%
NHP	30.8%	36.4%
Quartz	10.0%	10.0%
SHP	43.3%	43.3%
UHC	12.5%	12.5%
Statewide	**24.9%**	**26.1%**

The tables below provide more detail on calls that didn't reach a provider or did not obtain an appointment.

Table 101. Statewide Secret Shopper Unable to Reach Reason

Unable to Reach Reason	Provider Count
Invalid phone number	8
Non-responsive provider	3
Total	**11**

Table 102. Statewide Secret Shopper Unable to Obtain Appointment Reason

Unable to Obtain Appointment Reason	Provider Count
Provider does not accept new patients under any circumstances	57
Office representative did not give a definitive answer or did not know if the provider accepts the MCO	46
Personal information or additional steps required to receive appointment date	39
Provider is not primary care	23
Provider no longer with group or indicated location	18
Does not accept MCO and/or program	16
Office is not aware of the provider	6
Registration requirement before office will discuss provider details	4
Provider accepts patients with pre-existing conditions only/existing families only	4
Provider only sees certain populations	3
Other	14
Total	**230**

The most prevalent reason for not obtaining an appointment was due to providers not accepting new patients under any circumstances, followed by an incomplete answer from the office representative regarding the provider accepting the MCO's insurance.

Appointment Wait Time Results

Appointment wait times are the time from the initial request for health care services to the earliest date offered for an appointment for services. The date the completed secret shopper call was made and the date the appointment was offered were used to calculate the number of business days between the call and the appointment date. These days were compared to appointment availability standards established by DHS per the MCO Provider Network Adequacy Standards document. The tables below show the appointment wait time compliance with the DHS standards.

Table 103. Appointment Wait Time Results by MCO

MCO	Percentage Meeting the Standard	Number of Appointments Offered	Median Wait Time from Secret Shopper Survey (business days)
Anthem	68.8%	16	7.5
CCHP	28.6%	7	27
DHP	12.5%	8	37
GHC-EC	N/A	0	N/A
GHC-SCW	0.0%	2	281
*i*Care	80.0%	5	2
MCHP	37.5%	8	23
MHS	50.0%	8	37
MHWI	50.0%	2	23.5
NHP	50.0%	8	37
Quartz	0.0%	2	43
SHP	30.8%	13	38
UHC	57.1%	7	13
Statewide	**44.2%**	**86**	**20**

Table 104. Statewide Appointment Wait Times Meeting Standard

Description	Provider Count
Number of appointments offered (denominator)	78
Number of appointments not meeting the standard	44
Number of appointments meeting the standard (numerator)	34
Percentage of appointments meeting the standard	**43.6%**

Additional Network Adequacy Analyses

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

Grievance and Appeal Review

Grievances and appeals filed in CY 2024 with the MCOs as well as grievances and appeals filed with DHS and the Division of Hearings and Appeals were reviewed to identify any concerns related to network adequacy, including potential service gaps. This analysis helps to uncover

patterns regarding member grievances regarding care, and the types of services that are requested but denied.

Table 105. Statewide Network Adequacy Grievances by Service Type

Service Type	Count	Percent of Total
Dental Services	198	7.1%
Durable Medical Equipment/Supplies	93	3.3%
Inpatient/Outpatient Hospital	298	10.7%
Other	934	33.5%
Total	**2,788**	**100.0%**

Table 106. Statewide Network Adequacy Appeals by Service Type

Service Type	Count	Percent of Total
Dental Services	350	15.7%
Durable Medical Equipment/Supplies	244	10.9%
Inpatient/Outpatient Hospital	301	13.5%
Other	715	32.1%
Total	**2,229**	**100.0%**

The most common issues that caused grievances included payment/billing issues and access to care. The most common issues that resulted in an appeal were service denials and limited authorizations. The most common services that resulted in a grievance and/or appeal included dental services, access or approval of durable medical equipment/supplies, inpatient/ outpatient hospital services, and other.

Provider Directory Match

To measure the completeness of the MCO's provider directory, the MCO's provide network in the HPN file is geocoded and compared against the unique geocoded locations in the MCO's downloadable 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 107. Statewide Provider Directory Location Match

Program	CY 2024 Percent of Locations	CY 2025 Percent of Locations
BC+ and SSI	36.4%	25.6%

Actual Use of Care (Ghost Providers)

In order to determine the number of providers who are actively providing service in the MCOs' networks, the HPN extract was matched against encounters submitted in CY 2024. The results below show the number of providers, based on rendering NPI, which had at least one encounter during the measurement year. The tables below show the overall result results by provider type.

Table 108. Additional Network Adequacy Analysis Results: Actual Use of Care (Ghost Providers) Overall

Programs	Result
BC+ and SSI	88.4%

Table 109. Additional Network Adequacy Analysis Results: Actual Use of Care (Ghost Providers) by Provider Type

Provider Type	Provider Match	Total Providers	Percent Match
Dental – Adult	1,728	2,191	78.9%
Mental Health & Substance Use Providers	9,388	11,077	84.8%
OB/GYN	27,338	30,290	90.3%
PCP – Adult Population	101,732	114,634	88.7%
PCP – Pediatric Population	112,728	126,598	89.0%

Note: Since the same provider can be included in multiple provider types, the aggregate of these results will not equal the overall results.

Validation of Network Adequacy - State Level Findings

The table below identifies strengths, weaknesses/opportunities for improvement, and recommendations for each standard reviewed. Strengths were 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 110. State Level NAV Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Assessment of Network Adequacy Data, Methods, and Results
Reliability and Validity of Network Adequacy Data
Strengths: DHS provided detailed information about the data sources used for network adequacy calculations. The MCO Provider Network (HPN) and MCO Facilities Network (HFN) datasets are submitted to the state with an attestation from the MCO on the data's accuracy. Member data is sourced from the state's MMIS which is reconciled with the network adequacy dashboard by age group.
Weaknesses/Opportunities for Improvement: DHS has identified challenges with accurately identifying provider types in some instances.
Recommendations: DHS is working towards improvements to the process in Phase II of the network adequacy dashboard project with SAS, DHS's data warehouse vendor. Among the improvements include enhanced provider type identification.
Network Adequacy Assessment Methods
Strengths: DHS utilizes ESRI analysis software with SAS Explore and Visualization analytics to assess network adequacy indicators. Each MCO is assigned a BQO analyst who evaluates the network adequacy results and produces an annual report and scorecard.
Weaknesses/Opportunities for Improvement: The QA process only looks at potential outlier results when identified by an analyst.
Recommendations: DHS is working towards improvements to the process in Phase II of the network adequacy dashboard project with SAS. These improvements include trend analysis to improve QA of the results.
Network Adequacy Results
Strengths: • **Drive time and distance / Member to Provider Ratio:** The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval" have met network adequacy standards. • **Wait Time to Receive Services:** None identified.
Weaknesses/Opportunities for Improvement: • **Drive time and distance / Member to Provider Ratio:** The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval with Conditions," "Denied," and "Decertified" have not met network adequacy standards.

Assessment of Network Adequacy Data, Methods, and Results
• **Wait Time to Receive Services:** The wait time to receive an appointment across all MCO provider networks was at or below the 15-business day standard in 34 out of 78 appointments, which results in 43.6 percent. Common barriers to receiving an appointment were the provider not accepting new patients, the provider not accepting the MCO plan, or personal information being required to receive an appointment date.
Recommendations: • **Drive time and distance / Member to Provider Ratio:** The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • **Wait Time to Receive Services:** Improve provider networks to reduce the wait time to receive an appointment.

Validation of Network Adequacy – Managed Care Organization Level Findings

Anthem Blue Cross and Blue Shield Health Plan

The following results provide an overview of the network adequacy validation for Anthem.

Table 111. Anthem Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement
• The provider directory was not available in a downloadable format. For the online directory, the requirement of a zip code or county may be too limiting, even if it is meant to find providers near the member's home. Filters appear to work well for isolating the type of provider or facility desired. Many physicians' assistants and nurse practitioners do not have a specialty listed in the directories or cannot be found in the directory. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval with Conditions", "Denied", and "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: The wait time to receive an appointment in Anthem's provider network was at or below the 15-business day standard in 11 out of 16 appointments, resulting in a 68.8 percent result. A common barrier to receiving an appointment was the provider not accepting new patients or not accepting Anthem BC+.
Recommendations

Network Adequacy
• Ensure the directory is available in a downloadable format and allow provider searches without a zip code or county requirement. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Improve provider network to reduce the wait time to receive an appointment.

Chorus Community Health Plan Health Plan and Care4Kids

The following results provide an overview of the network adequacy validation for CCHP.

Table 112. CCHP and C4K Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• CCHP's information system was fully compliant with all NCQA defined standards for HEDIS® data and processes. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement
• The provider directory was not available in a downloadable format, and the online directory did not include the provider's website or the provider's cultural competency training. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval with Conditions," "Denied," and "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: The wait time to receive an appointment in CCHP's provider network was at or below the 15-business day standard in two out of seven appointments, reflecting a 28.6 percent result. A common barrier to receiving an appointment was the providers' lack of knowledge or not accepting CCHP BC+.
Recommendations
• Ensure the directory is available in a downloadable format and includes more provider information to enhance the member experience. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Improve the provider network to reduce the wait time to receive an appointment and increase provider education on the availability of CCHP BC+ for providers.

Dean Health Plan, Inc.

The following results provide an overview of the network adequacy validation review for DHP.

Table 113. DHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• DHP's information system was fully compliant with all NCQA defined standards for HEDIS® data and processes. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement
• The provider directory did not include the provider's cultural competency training. Additionally, the online directory would often freeze while searching for providers, requiring the page to be reloaded. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval with Conditions," "Denied," and "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: The wait time to receive an appointment in DHP's provider network was at or below the 15-business day standard in one out of eight appointments, reflecting a 12.5 percent result. A common barrier to receiving an appointment was the provider not accepting DHP BC+.
Recommendations
• Ensure the online directory is improved to reduce the issue during provider searches. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Improve the provider network to reduce the wait time to receive an appointment. Increase provider education on the availability of DHP BC+ for the providers in their network.

Group Health Cooperative of Eau Claire

The following results provide an overview of the network adequacy validation for GHC-EC.

Table 114. GHC-EC Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• GHC-EC's information system was fully compliant with all NCQA defined standards for HEDIS® data and processes. • Drive time and distance / Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement

Network Adequacy
• Drive time and distance / Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS summarized the results by county and program. Counties with "Approval with Conditions," "Denied," or "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: The wait time to receive an appointment in GHC-EC's provider network was not available since no appointments were offered. A common barrier to receiving an appointment was the provider lack of knowledge or not accepting GHC-EC BC+.
Recommendations
• Drive time and distance / Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Increase provider education on the availability of GHC-EC BC+ for providers and verify providers listed in the network accept GHC-EC.

Group Health Cooperative of South-Central Wisconsin

The following results provide an overview of the network adequacy validation for GHC-SCW.

Table 115. GHC-SCW Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• GHC-SCW's information system was fully compliant with all NCQA defined standards for HEDIS® data and processes. • The MCO's online directory was user-friendly and included effective filter options for locating relevant provider information. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS summarized these results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement
• Drive time and distance / Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS summarized these results by county and program. Counties with "Approval with Conditions," "Denied," or "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: The wait time to receive an appointment in GHC-SCW's provider network met the 15-business day standard in zero out of two appointments, resulting in a compliance rate of 0.0 percent. A common barrier to receiving an appointment was the limited availability of primary care physicians; physician assistants, and nurse practitioners to accept new patients.
Recommendations
• Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports summarized these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Expand the provider network to ensure timely access to appointments.

Independent Care Health Plan

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

Table 116. *i*Care Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• *i*Care's information system was fully compliant with all NCQA defined standards for HEDIS® data and processes. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS summarized the results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement
• The online directory did not include the provider's website, the provider's cultural competency training, or accommodations for people with physical disabilities. The board certification details were commonly absent, often identifying values of "Not Reported" or "Not Available." The website occasionally experienced slow performance and page rendering issues, which made it difficult to determine when a search was in progress or completed. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS summarized these results by county and program. Counties with "Approval with Conditions," "Denied," or "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: The wait time to receive an appointment in *i*Care's provider network met the 15-business day standard in four out of five appointments, resulting in a compliance rate of 80.0 percent. A common barrier to receiving an appointment was the provider's lack of knowledge regarding insurance networks they participate in or not accepting *i*Care BC+.
Recommendations
• Enhance the online directory with additional provider information and address webpage performance issues to improve the member experience. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS summarized the results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Expand the provider network to reduce the wait time to receive an appointment and increase provider education on the availability of *i*Care BC+.

MercyCare Health Plans

The following results provide an overview of the network adequacy validation for MCHP.

Table 117. MCHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• MCHP's information system was fully compliant with all NCQA defined standards for HEDIS® data and processes. • The online provider directory featured a user-friendly design with links to view all providers at each facility, provider availability for new patients, and maps to each location. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS summarized these results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement
• Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS summarized these results by county and program. Counties with "Approval with Conditions," "Denied," or "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: The wait time to receive an appointment in MCHP's provider network met the 15-business day standard in three out of eight appointments, resulting in a compliance rate of 37.5 percent. Common barriers to receiving an appointment were that the provider was no longer at that location, was not accepting new patients, or required personal information to schedule the appointment.
Recommendations
• Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS summarized these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Expand the provider network to ensure timely access appointments.

MHS Health Wisconsin

The following results provide an overview of the network adequacy validation for MHS.

Table 118. MHS Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• MHS's information system was fully compliant with all NCQA defined standards for HEDIS® data and processes. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement
• CAHPS® Term data as of January 1, 2025, was mostly incorrect. • The online directory did not include the provider's website or the provider's cultural competency training, and most values for accommodations for physical disabilities were listed as "details

Network Adequacy
pending." A performance issue was noted: the website became unresponsive after two searches. To resolve the issue, the page was reloaded and the search process restarted. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval with Conditions," "Denied," or "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: In MHS's provider network, the wait time to receive an appointment was at or below the 15-business day standard in four out of eight appointments, reflecting a 50.0 percent result. A common barrier to receiving an appointment was the provider not accepting MHS BC+.
Recommendations
• The plan must correctly identify the number of individuals no longer enrolled in the Qualified Health Plan to support benchmarking. • Expand provider information in the directory and investigate the performance issue to enhance the member experience. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Improve the provider network to reduce the wait time to receive an appointment.

Molina Healthcare of Wisconsin

The following results provide an overview of the network adequacy validation for MHWI.

Table 119. MHWI Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• MHWI's information system was fully compliant with all NCQA defined standards for HEDIS® data and processes. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement
• The online directory did not include the provider website or the provider cultural competence training. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties marked "Approval with Conditions," "Denied," or "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: In MHWI's provider network, the wait time to receive an appointment was at or below the 15-business day standard in one out of two appointments, resulting in a 50.0 percent result. A common barrier to receiving an appointment was the provider's lack of knowledge or not accepting MHWI BC+.

Network Adequacy
Recommendations
• Expand the provider's information in the directory to enhance the member experience. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Improve the provider network to reduce the wait time to receive an appointment. Increase provider education on the availability of MHWI BC+ for the providers in their network.

Network Health Plan

The following results provide an overview of the network adequacy validation for NHP.

Table 120. NHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• NHP's information system was fully compliant with all NCQA defined standards for HEDIS® data and processes. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement
• The online directory did not include the provider's website or the provider's cultural competency training, and most values for accommodations for physical disabilities were listed as "details pending." A performance issue was noted: the website became unresponsive after two searches. To resolve the issue, the page was reloaded and the search process restarted. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval with Conditions," "Denied," or "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: In NHP's provider network, the wait time to receive an appointment was at or below the 15-business day standard in four out of eight appointments, reflecting a 50.0 percent result. A common barrier to receiving an appointment was the provider not accepting NHP BC+.
Recommendations
• Expand provider information in the directory and investigate the performance issue to enhance the member experience. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Improve the provider network to reduce the wait time to receive an appointment.

Quartz Health Solutions, Inc.

The following results provide an overview of the network adequacy validation for Quartz.

Table 121. Quartz Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• Quartz's information system was fully compliant with all NCQA defined standards for HEDIS® data and processes. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement
• The online directory included the provider's board certification but most of the providers tested had "none" listed in this field. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval with Conditions," "Denied," and "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: The wait time to receive an appointment in Quartz's provider network was at or below the 15-business day standard in zero out of two appointments, resulting in a 0.0 percent result. A common barrier to receiving an appointment was the provider's lack of knowledge or not accepting Quartz BC+.
Recommendations
• Ensure that the directory includes more provider information to enhance the member's experience. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Improve the provider network to reduce the wait time to receive an appointment. Increase provider education on the availability of Quartz BC+ for the providers in their network.

Security Health Plan of Wisconsin

The following results provide an overview of the network adequacy validation for SHP.

Table 122. SHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• SHP's information system was fully compliant with all NCQA defined standards for HEDIS® data and processes. • The online directory was easy to navigate, included provider information on cultural competence training, and was available to download in a machine-readable format.

Network Adequacy
• Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement
• Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval with Conditions," "Denied," or "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: The wait time to receive an appointment in SHP's provider network was at or below the 15-business day standard in four out of 13 appointments, resulting in a 30.8 percent result. A common barrier to receiving an appointment was the provider not accepting SHP BC+.
Recommendations
• Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Improve the provider network to reduce the wait time to receive an appointment.

United Healthcare Community Plan

The following results provide an overview of the network adequacy validation for UHC.

Table 123. UHC Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Network Adequacy
Strengths
• UHC's information system was fully compliant with all NCQA defined standards for HEDIS® data and processes. • The online provider directory was easy to search and provided helpful information such as reviews, parking or public access information, accepted patient ages, office hours, and multiple practice locations. • The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval" have met network adequacy standards.
Weaknesses/Opportunities for Improvement
• Several sources failed primary source verification or required corrective action prior to approval. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. Counties with "Approval with Conditions, "Denied," or "Decertified" have not met network adequacy standards. • Wait Time to Receive Services: The wait time to receive an appointment in UHC's provider network was at or below the 15 business day standard in four out of seven appointments, reflecting a 57.1 percent result. A common barrier to receiving an appointment was the provider not accepting new patients, not accepting UHC BC+, or not sure if they accepted UHC.
Recommendations

Network Adequacy
• Improve clinical data source quality. • Drive Time and Distance/Member to Provider Ratio: The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. • Wait Time to Receive Services: Improve the provider network to reduce the wait time to receive an appointment, and increase provider education on the availability of UHC BC+.

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 124. 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/Actions taken did not address recommendations.

The table below 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.

Table 125. State-Level Progress on Prior Recommendations

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
○ Data Collection Procedures ○ There were no unmet areas for data collection procedures. ○ Network Adequacy Methods ○ There were no unmet areas for network adequacy methods. ○ Network Adequacy Results ○ Adult Dental Providers	**Drive Time and Distance/Member to Provider Ratio:** – The MCOs' Network Adequacy Compliance Letters from DHS report on these results by county and program. DHS expects the MCOs to remediate their provider network as described in the letter. **Wait Time to Receive Services:**	Not Applicable

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
• Issue for four of 13 MCOs. ○ Pediatric Dental Providers • Issue for eight of 13 MCOs. ○ Adult and Pediatric (12 - 18) OB/GYN • Issue for all 13 MCOs. ○ Adult Primary Care Providers • Issue for seven of 13 MCOs. ○ Pediatric Primary Care Providers • Issue for 11 of 13 MCOs. ○ Adult and Pediatric Psychiatrist and Psychologist Providers • Issue for 12 of 13 MCOs.	– This is the first review for the organizations' wait time to receive services; therefore, no previous results are available to determine progress.	

The table below identifies the recommendations made by the EQRO in the prior review of the standards, the actions taken by the organizations to address the recommendations, and the degree to which each addressed the recommendations.

Table 126. MCO-Level Progress

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Anthem	– Improve the network of providers in the service types that did not meet the provider to enrollee ratio standard in all counties: ○ Dental providers for adult and pediatric populations were the top issue for the BC+ and SSI programs. Two counties did not meet the standard for BC+ and all six counties did	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. Wait Time to Receive Services:	Not Applicable

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	not meet the standard for SSI. ○ For BC+, the Psychiatrist and Psychologist and OB/GYN provider types did not meet the standard for three counties or less. ○ For SSI, the Psychiatrist and Psychologist, and Pediatric PCP types did not meet the standard for five counties or less.	– This is the first review for the organization's wait time to receive services, therefore no previous results are available to determine progress.	
CCHP	– Improve the network of providers in the service types that did not meet the provider to enrollee ratio standard in all counties: ○ Dental providers for adult and pediatric populations were the top issue for the BC+ program with most counties not meeting the standard. ○ For BC+, the Psychiatrist and Psychologist, and OB/GYN provider types did not meet the standard for two counties or less. – For C4K, Pediatric Dental did not meet the standard in one county.	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. Wait Time to Receive Services: – This is the first review for the organization's wait time to receive services, therefore no previous results are available to determine progress.	Not Applicable
DHP	– Improve the network of providers in the service types that did not meet the provider to enrollee ratio standard in all counties: ○ For BC+, the Psychiatrist and Psychologist, and	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate	Not Applicable

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	OB/GYN provider types did not meet the standard for six counties or less.	their provider network as described in the letter. Wait Time to Receive Services: – This is the first review for the organization's wait time to receive services, therefore no previous results are available to determine progress.	
GHC-EC	– Improve the network of providers in the service types that did not meet the provider to enrollee ratio standard in all counties: ○ For BC+, the Psychiatrist and Psychologist, OB/GYN, and PCP provider types did not meet the standard for 26 counties or less. – For SSI, the Psychiatrist and Psychologist, OB/GYN, and Pediatric PCP provider types did not meet the standard for 18 counties or less.	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. Wait Time to Receive Services: – This is the first review for the organization's wait time to receive services, therefore no previous results are available to determine progress.	Not Applicable
GHC-SCW	– Expand the provider network for service types that did not meet the provider to enrollee ratio standard in all counties; ○ Psychiatrist and Psychologist, OB/GYN, and PCP provider types did not meet the standard for four counties or less.	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. Wait Time to Receive Services: – This is the first review for the organization's wait time to receive services, therefore no	Not Applicable

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
		previous results are available to determine progress.	
*i*Care	– Improve the network of providers in the service types that did not meet the provider to enrollee ratio standard in all counties; ○ For BC+, the Pediatric Dental, Psychiatrist and Psychologist, OB/GYNy, and PCP provider types did not meet the standard for 26 counties or less. – For SSI, the Pediatric Dental, Psychiatrist and Psychologist, OB/GYN, and PCP provider types did not meet the standard for 18 counties or less.	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. Wait Time to Receive Services: – This is the first review for the organization's wait time to receive services, therefore no previous results are available to determine progress.	Not Applicable
MCHP	– Expand the provider network for the service types that did not meet the provider-to-enrollee ratio standard in all counties: – OB/GYN and PCP providers were the top issue for the BC+ program with all counties not meeting the standard.	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. Wait Time to Receive Services: – This is the first review for the organization's wait time to receive services, therefore no previous results are available to determine progress.	Not Applicable
MHS	– Improve the network of providers in the service types that did not meet the	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS	Not Applicable

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	provider to enrollee ratio standard in all counties; ○ For BC+, the Pediatric Dental, Psychiatrist and Psychologist, and OB.GYN provider types did not meet the standard for 12 counties or less. – For SSI, the Pediatric Dental, Psychiatrist and Psychologist, OB/GYN, and Pediatric PCP provider types did not meet the standard for 12 counties or less.	reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. Wait Time to Receive Services: – This is the first review for the organization's wait time to receive services, therefore no previous results are available to determine progress.	
MHWI	– Improve the network of providers in the service types that did not meet the provider to enrollee ratio standard in all counties: – For BC+, the Psychiatrist and Psychologist, OB/GYN, and PCP provider types did not meet the standard for nine counties or less. – For SSI, the Psychiatrist and Psychologist, OB/GYN, and Pediatric PCP provider types did not meet the standard for 15 counties or less.	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. Wait Time to Receive Services: – This is the first review for the organization's wait time to receive services, therefore no previous results are available to determine progress.	Not Applicable
NHP	– Improve the network of providers in the service types that did not meet the provider to enrollee ratio standard in all counties: ○ For BC+, the Pediatric Dental, Psychiatrist and	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate	Not Applicable

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	Psychologist, and OB/GYN provider types did not meet the standard for 12 counties or less. ○ For SSI, the Pediatric Dental, Psychiatrist and Psychologist, OB/GYN, and Pediatric PCP provider types did not meet the standard for 23 counties or less.	their provider network as described in the letter. Wait Time to Receive Services: – This is the first review for the organization's wait time to receive services, therefore no previous results are available to determine progress.	
Quartz	– Improve the network of providers in the service types that did not meet the provider to enrollee ratio standard in all counties: ○ For BC+ the Psychiatrist and Psychologist provider type did not meet the standard for five counties. – For SSI, none of the provider types met the standard in any county.	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. Wait Time to Receive Services: – This is the first review for the organization's wait time to receive services, therefore no previous results are available to determine progress.	Not Applicable
SHP	– Improve the network of providers in the service types that did not meet the provider to enrollee ratio standard in all counties: ○ For BC+, the Psychiatrist and Psychologist, OB/GYN, and PCP provider types did not meet the standard for 23 counties or less.	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. Wait Time to Receive Services: – This is the first review for the organization's wait time to	Not Applicable

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	○ For SSI, the Psychiatrist and Psychologist provider type did not meet the standard for one county.	receive services, therefore no previous results are available to determine progress.	
UHC	– Improve the network of providers in the service types that did not meet the provider to enrollee ratio standard in all counties: ○ For BC+, the Dental, Psychiatrist and Psychologist, and OB/GYN provider types did not meet the standard for six counties or less. ○ For SSI the Pediatric Dental, Psychiatrist and Psychologist, OB/GYN, and Pediatric PCP{ provider types did not meet the standard for seven counties or less.	Drive Time and Distance/Member to Provider Ratio: – The MCO's Network Adequacy Compliance Letter from DHS reports on these results by county and program. DHS expects the MCO to remediate their provider network as described in the letter. Wait Time to Receive Services: – This is the first review for the organization's wait time to receive services, therefore no previous results are available to determine progress.	Not Applicable

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

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

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

Screening

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

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

- The member's chronic physical health needs (including dental);
- The member's chronic mental and behavioral health needs (including alcohol and other drug abuse);
- The member's perception of their strengths and general well-being;

- If the member has a usual source of care;
- Any indirect supports the member may have;
- Any relationships the member may have with community resources;
- Any immediate and/or long-term member concerns about their overall well-being including SDoH;
- ADLs; and
- IADLs.

Care Planning

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

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

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

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

Care Coordination

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

Care Plan Review and Update

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

- Significant changes to medical and/or behavioral health needs;
- Changes in needs strata;

- Member non-responsiveness to the care plan;
- Frequent transitions between care settings; and
- Member request or identification of a problem/gap not previously addressed.

Transition Planning

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

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

Wisconsin Interdisciplinary Care Team

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

- At least two licensed health care professionals (with access to multiple disciplines);
- Weekly WICT Core Team meetings to discuss the entirety of their shared caseload; and
- A monthly face-to-face meeting between a member of the WICT Core Team and the member.

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 127. SSI CMR Review Tool

Indicator	Indicator Label	Indicator Description
1.1	The screen was completed within the required timeframe.	Documentation includes timely contact and evidence that the screen was completed within the required timeframe.
1.2	The screen included all required elements.	Documentation must show that all required screening elements were addressed. Applies only to records with a completed screen.
2.1	The care plan was completed within the required timeframe.	Documentation includes timely contact and evidence that the care plan was completed within the required timeframe.

Indicator	Indicator Label	Indicator Description
2.2	The care plan included all required elements.	Documentation must show that all required components of the care plan were addressed and completed. Applies only to records with a completed care plan.
2.3	The care plan was shared with all required team members.	Documentation must confirm that the care plan was distributed to all required team members. Applies only to records with a completed care plan.
2.4	The member or authorized representative agreed to the care plan prior to its implementation.	Documentation must show that the member or their authorized representative reviewed and agreed to the care plan before it was implemented. Applies only to records with a completed care plan.
3.1	The care management team contacted the member once every 12 months or more frequently based on the member's stratification level.	Documentation includes contact and evidence that the care plan was revised in response to changes in the member's needs.
3.2	The care management team addressed and provided timely follow-up of the member's needs.	Documentation must confirm that the care management team identified the members' needs and took timely follow-up actions to address the needs. Applies only to records that evidence a follow-up need.
4.1	The care plan was reviewed at least once every 12 months.	Documentation includes timely contact and evidence that the care plan was reviewed within the required 12-month timeframe. Applies only to records with member enrollment 12 months or more.
4.2	The care plan was updated for changing member needs.	Documentation must confirm that the care plan was reviewed and revised in response to changes in the member's condition, preferences, or circumstances, ensuring it remains aligned with the member's current needs. Applies only to records with changing member needs.

Indicator	Indicator Label	Indicator Description
4.3	The members' stratification was reassessed after a critical event.	Documentation must confirm that the member's risk stratification level was reviewed and updated, if necessary, following a critical event such as hospitalization, significant change in health status, or other major care transition. Applies only to records with critical events.
5.1	The member was contacted within five business days of discharge from an inpatient hospital facility.	Documentation includes contact within five business days of a discharge from an inpatient hospital facility. Applies only to records with hospitalizations.
5.2	The transition care follow-up included the review of hospital discharge information with the member within the required timeframe.	Documentation must confirm that hospital discharge information was reviewed with the member as part of the transition care follow-up, and that this review occurred within the required timeframe Applies only to records with hospitalizations.
6.1	The WICT Core Team included at minimum two licensed health care providers.	Documentation must verify that the WICT Core Team includes at least two licensed healthcare providers, in compliance with staffing requirements. Applies only to records stratified as WICT.
6.2	The WICT Core Team met at minimum weekly to discuss the member.	Documentation must show that the WICT Core Team met at least weekly to discuss the member's care, ensuring consistent coordination and oversight. Applies only to records stratified as WICT.
6.3	The WICT Core Team met once a month face-to-face with the member.	Documentation must confirm that the WICT Core Team held face-to-face meetings with the member at least once per month, in accordance with program requirements. Applies only to records stratified as WICT.

To conduct the review, MetaStar selects a random sample of members from each MCO. Each MCO has a different review period, as reviews are conducted on a rolling basis. The random sample included a mix of members who enrolled during the last year, members who had been enrolled for more than 90 consecutive days, and members who had left the program since the

sample was generated. The tables below show the sample sizes and review periods for each MCO and program.

Table 128. SSI Samples Sizes and Review Period

MCO	Records Reviewed	Review Period
Anthem	161	July 1, 2024 – June 30, 2025
GHC-EC	156	January 1, 2024 – December 31, 2024
*i*Care	161	July 1, 2024 – June 30, 2025
MHS	160	January 1, 2024 – December 31, 2024
MHWI	159	July 1, 2024 – June 30, 2025
NHP	158	January 1, 2024 – December 31, 2024
Quartz	102	July 1, 2024 – June 30, 2025
SHP	126	January 1, 2024 – December 31, 2024
UHC	147	July 1, 2024 – June 30, 2025

Care Management Review – Results

This report addresses the evaluation of care management practices for the review periods specified in the table above, with reviews conducted in CY 2025. Compliance is expressed 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 129. SSI CMR 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

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 review 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 changes 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 SSI program for CY 2025. For comparison, the score from CY 2024 is also included, along with the direction of change.

Table 130. SSI CMR Results

Indicator	Indicator Label	CY 2025 Percentage Score	Compliance Rating	CY 2024 Percentage Score	Change
1.1	The screen was completed within the required timeframe.	28.2%	Not Met	25.6%	NS
1.2	The screen included all required elements.	92.6%	Fully Met	93.7%	NS
2.1	The care plan was completed within the required timeframe.	38.3%	Not Met	37.2%	NS
2.2	The care plan included all required elements.	83.4%	Substantially Met	85.8%	NS
2.3	The care plan was shared with all required team members.	78.7%	Partially Met	75.8%	NS
2.4	The member or authorized representative agreed to the care plan prior to its implementation.	84.0%	Substantially Met	94.7%	▼
3.1	The care management team contacted the member once every 12 months or more frequently based on the member's stratification level.	44.9%	Not Met	27.5%	▲
3.2	The care management team addressed and provided timely follow-up of the member's needs.	84.0%	Substantially Met	74.8%	▲

Indicator	Indicator Label	CY 2025 Percentage Score	Compliance Rating	CY 2024 Percentage Score	Change
4.1	The care plan was reviewed at least once every 12 months.	20.5%	Not Met	22.0%	NS
4.2	The care plan was updated for changing member needs.	56.7%	Not Met	67.5%	NS
4.3	The members' stratification was reassessed after a critical event.	64.5%	Minimally Met	62.3%	NS
5.1	The member was contacted within five business days of discharge from an inpatient hospital facility.	32.1%	Not Met	44.7%	▼
5.2	The transition care follow-up included the review of hospital discharge information with the member within the required timeframe.	26.7%	Not Met	40.9%	▼
6.1	The WICT Core Team included at minimum two licensed health care providers.	95.8%	Fully Met	91.2%	NS
6.2	The WICT Core Team met at minimum weekly to discuss the member.	83.3%	Substantially Met	85.3%	NS
6.3	The WICT Core Team met once a month face-to-face with the member	64.3%	Minimally Met	47.1%	NS

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

The table below displays the percentage scores achieved by each SSI MCO in CY 2025.

Table 131. SSI CMR Results by MCO

Ind.	Ind. Label	Anthem	GHC-EC	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
1.1	The screen was	38.4%	56.8%	26.8%	30.0%	11.7%	22.9%	14.7%	28.0%	19.0%

Ind.	Ind. Label	Anthem	GHC-EC	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
	completed within the required timeframe.									
1.2	The screen included all required elements.	100.0%	96.0%	96.9%	100.0%	86.5%	100.0%	82.8%	58.5%	81.3%
2.1	The care plan was completed within the required timeframe.	44.7%	80.6%	42.0%	40.0%	20.8%	26.8%	21.0%	29.8%	30.6%
2.2	The care plan included all required elements.	62.5%	92.8%	71.2%	100.0%	100.0%	100.0%	20.8%	90.0%	84.4%
2.3	The care plan was shared with all required team members.	75.0%	89.6%	87.9%	73.4%	81.3%	69.8%	20.8%	92.5%	73.3%
2.4	The member or authorized representative agreed to the care plan prior to its implementation.	12.5%	100.0%	81.8%	98.4%	100.0%	97.7%	87.5%	97.5%	97.8%
3.1	The care managemen	41.2%	82.7%	52.5%	35.1%	36.4%	34.0%	42.9%	49.6%	27.7%

Ind.	Ind. Label	Anthem	GHC-EC	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
	t team contacted the member once every 12 months or more frequently based on the member's stratificatio n level.									
3.2	The care managemen t team addressed and provided timely follow-up of the member's needs.	77.1%	95.1%	92.6%	76.9%	75.8%	76.9%	66.7%	93.3%	96.9%
4.1	The care plan was reviewed at least once every 12 months.	15.4%	56.2%	23.1%	20.6%	6.0%	13.3%	14.3%	17.4%	12.5%
4.2	The care plan was updated for changing member needs.	0.0%	83.3%	88.2%	50.0%	50.0%	40.0%	50.0%	50.0%	60.0%
4.3	The members'	83.9%	63.6%	75.9%	90.5%	36.4%	53.3%	40.0%	42.1%	72.7%

Ind.	Ind. Label	Anthem	GHC-EC	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
	stratification was reassessed after a critical event.									
5.1	The member was contacted within five business days of discharge from an inpatient hospital facility.	18.5%	60.0%	52.9%	35.7%	22.2%	22.2%	28.6%	33.3%	29.4%
5.2	The transition care follow-up included the review of hospital discharge information with the member within the required timeframe.	14.8%	40.0%	52.9%	21.4%	22.2%	11.1%	14.3%	33.3%	29.4%
6.1	The WICT Core Team included at minimum two licensed	66.7%	100.0%	100.0%	N/A	N/A	N/A	N/A	N/A	N/A

Ind.	Ind. Label	Anthem	GHC-EC	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
	health care providers.									
6.2	The WICT Core Team met at minimum weekly to discuss the member.	0.0%	90.0%	100.0%	N/A	N/A	N/A	N/A	N/A	N/A
6.3	The WICT Core Team met once a month face-to-face with the member	0.0%	50.0%	80.0%	N/A	N/A	N/A	N/A	N/A	N/A

Care Management Review - State Level Findings

The table below identifies strengths, weaknesses/opportunities for improvement, and recommendations for each standard reviewed. Strengths were given for standards that were 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 132. SSI CMR Strengths, Weaknesses/Opportunities for Improvement and Recommendations

Screening
Strengths: None identified.
Weaknesses/Opportunities for Improvement: The organizations did not complete member screens within 60 days of enrollment or re-enrollment, and annually thereafter.
Recommendations: Complete member screens within 60 days of enrollment or re-enrollment, and annual thereafter.
Care Planning
Strengths: None identified.

Screening
Weaknesses/Opportunities for Improvement: The organizations did not complete care plans within the required timeframes, either 30 days after screening or 90 days post-enrollment, whichever came first. Documentation did not include all contract-required elements, such as member-centered goals, sequenced interventions, readiness to self-manage, and supports addressing physical, behavioral, and dental health, medications, ADLs/IADLs, and SDoH. Care plans were not shared with all required team members, and missing documented member agreement prior to implementation. When applicable, consent from legal representatives was not properly recorded.
Recommendations: Complete care plans within required timeframes, either 30 days after screening or 90 days post-enrollment, whichever comes first. Document all contract-required elements, including member-centered goals, sequenced interventions, readiness to self-manage, and supports addressing physical, behavioral, and dental health, medications, ADLs/IADLs, and SDoH. Share plans with all required team members and document member agreement prior to implementation. Record consent from legal representatives, when applicable.
Care Coordination
Strengths: None identified.
Weaknesses/Opportunities for Improvement: The organizations did not include member engagement and care plan oversight in alignment with contract expectations. Members were not contacted at the required frequency based on their stratification level, with a minimum of one contact every 12 months. Timely follow-up was not provided for all identified member needs and requests, such as physical/behavioral health, referral/resource coordination, advance care planning, social/community, SDoH, and program benefit assistance.
Recommendations: Maintain member engagement and care plan oversight in alignment with contract expectations. Contact members at the required frequency based on their stratification level, with a minimum of one contact every 12 months. For all members' needs and requests, ensure timely follow-up.
Care Plan Review and Updates
Strengths: None identified.
Weaknesses/Opportunities for Improvement: The organizations did not ensure care plans were reviewed at least annually and updated as needed to reflect changing member needs. Care plan updates prompted by significant medical or behavioral health changes, frequent transitions between care settings, or identification of care gaps by the care management team, were not completed. Following any critical event, the members' stratification level was not reassessed to ensure appropriate care coordination.
Recommendations: Ensure care plans are reviewed at least annually and updated as needed to reflect changing member needs. Update care plans when prompted by significant medical or behavioral health changes, frequent transitions between care settings, or identification of care gaps by the care management team. Reassess the members' stratification level following any critical event.
Transition Planning

Screening
Strengths: None identified.
Weaknesses/Opportunities for Improvement: The organizations did not ensure timely member follow-up after inpatient hospital discharge, which is to occur within five business days. Follow-up did not include medication reconciliation, assessment of the member's ability to manage medications, or support in understanding their treatment plan, medication schedule, and condition management.
Recommendations: Contact members for follow-up after inpatient hospital discharge, within five business days. Ensure all post hospitalization follow-up includes medication reconciliation, assessment of the member's ability to manage medications, and support in understanding their treatment plan, medication schedule, and condition management.
WICT
Strengths: None identified.
Weaknesses/Opportunities for Improvement: The organizations WICT Core Team did not meet weekly to discuss member needs. Monthly face-to-face meetings with members were not completed to ensure supportive collaborative care planning and strong provider-member relationships.
Recommendations: Ensure the WICT Core Team meets weekly to discuss member needs and completes monthly face-to-face meetings with members to establish supportive collaborative care planning and strong provider-member relationships.

Care Management Review – Managed Care Organization Level Findings

Anthem Blue Cross and Blue Shield Health Plan

The following results provide an overview of the SSI CMR for Anthem.

Table 133. Anthem Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Care Management Review
Strengths
• The organization ensured screens were comprehensive (1.2).
Weaknesses/Opportunities for Improvement
• Member screens were not timely (1.1). • Care plans were not completed within the required timeframes (2.1). • Care plans were not comprehensive (2.2). • Member care plans were not distributed to all required team members (2.3). • Care plan agreements were not obtained from the member or authorized representative prior to implementation (2.4). • Members were not contacted once every 12 months or more based on their stratification level (3.1). • Follow-up was not timely for member needs (3.2). • Member care plans were not updated at least once every 12 months (4.1).

Care Management Review
• Member care plans were not updated for changing member needs (4.2). • Members' stratification level was not reassessed after a critical event (4.3). • Members were not contacted within five business days of discharge from an inpatient hospital facility (5.1). • Transitional care follow-up did not include a review of hospital discharge information with the member within the required timeframe (5.2). • A minimum of two licensed health care providers in the Wisconsin Interdisciplinary Care Team was not present (6.1). • The Wisconsin Interdisciplinary Care Team did not meet at minimum weekly to discuss the member (6.2). • The Wisconsin Interdisciplinary Care Team did not conduct a once a month face-to-face visit with the member (6.3).
Recommendations
• Conduct member screens timely (1.1). • Complete care plans within the required timeframes (2.1). • Develop care plans that include all required elements (2.2). • Distribute care plans to all required team members (2.3). • Obtain care plan agreement from the member or authorized representative (2.4). • Contact members once every 12 months or more based on their stratification level (3.1). • Ensure timely follow-up for member needs (3.2). • Update the member care plan at least once every 12 months (4.1). • Update the member care plan for changing member needs (4.2). • Ensure members' stratification is reassessed after a critical event (4.3). • Contact members within five business days of discharge from an inpatient hospital facility (5.1). • Ensure transitional care follow-up includes a review of hospital discharge information with the member within the required timeframe (5.2). • Include a minimum of two licensed health care providers in the Wisconsin Interdisciplinary Care Team (6.1). • Ensure the Wisconsin Interdisciplinary Care Team meets at minimum weekly to discuss the member (6.2). • Ensure the Wisconsin Interdisciplinary Care Team conduct a monthly face-to-face visit with the member (6.3).

Group Health Cooperative of Eau Claire

The following results provide an overview of the SSI CMR for GHC-EC.

Table 134. GHC-EC Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Care Management Review
Strengths
• The organization ensured screens were comprehensive (1.2). • The organization ensured care plans were comprehensive (2.2).

Care Management Review
• The organization received care plan approval from the member or authorized representative prior to its implementation (2.4). • The organization's care management team provided timely follow-up of the members' needs (3.2). • The organization's Wisconsin Interdisciplinary Care Team included a minimum of two licensed health care providers (6.1). • The organization's Wisconsin Interdisciplinary Care Team met weekly to discuss member needs (6.2).
Weaknesses/Opportunities for Improvement
• Member screens were not completed timely (1.1). • Care plans were not completed within the required timeframes (2.1). • Member care plans were not distributed to all required team members (2.3). • Members were not contacted once every 12 months or more based on their stratification level (3.1). • Member care plans were not updated at least once every 12 months (4.1). • Member care plans were not updated for changing member needs (4.2). • Members' stratification level was not reassessed after a critical event (4.3). • Members were not contacted within five business days of discharge from an inpatient hospital facility (5.1). • Transitional care follow-up did not include a review of hospital discharge information with the member within the required timeframe (5.2). • The Wisconsin Interdisciplinary Care Team did not conduct a monthly face-to-face visit with the member (6.3).
Recommendations
• Complete member screens timely (1.1). • Prioritize care plan completion within the required timeframe (2.1). • Share care plans with all required team members (2.3). • Contact members once every 12 months or in accordance with their stratification level (3.1). • Prioritize annual care plan reviews (4.1). • Update care plans when a change in member needs is identified (4.2). • Ensure members' stratification is reassessed after a critical event (4.3). • Complete member contact within five business days of discharge from an inpatient hospital facility (5.1). • Ensure transition care follow-up includes a review of hospital discharge information with the member within the required timeframe (5.2). • Ensure the Wisconsin Interdisciplinary Care Team conduct a monthly face-to-face visit with the member (6.3).

Independent Care Health Plan

The following results provide an overview of the SSI CMR for *i*Care.

Table 135. *i*Care Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Care Management Review
Strengths
• The organization ensured screens were comprehensive (1.2). • The care management team ensured timely follow-up for member needs (3.2). • The Wisconsin Interdisciplinary Care Team Core Team included a minimum of two licensed health care providers (6.1). • The Wisconsin Interdisciplinary Care Team Core team provided timely collaboration (6.2).
Weaknesses/Opportunities for Improvement
• Member screens were not completed timely (1.1). • Care plans were not completed within the required timeframes (2.1). • Care plans were not comprehensive (2.2). • Member care plans were not distributed to all required team members (2.3). • Care plan agreements were not obtained from the member or authorized representative prior to implementation (2.4). • Members were not contacted once every 12 months or more based on their stratification level (3.1). • Member care plans were not updated at least once every 12 months (4.1). • Member care plans were not updated for changing needs (4.2). • Stratification levels were not reassessed after a critical event (4.3). • Member contact did not occur within five business days of discharge from an inpatient hospital facility (5.1). • Transitional care follow-up did not include a review of hospital discharge information with the member within the required timeframe (5.2). • The Wisconsin Interdisciplinary Care Team did not conduct a monthly face-to-face visit with the member (6.3).
Recommendations
• Complete member screens within the required timeframe (1.1). • Prioritize care plan completion within the required timeframe (2.1). • Develop comprehensive care plans (2.2). • Distribute care plans to all required team members (2.3). • Obtain care plan agreement from the member or authorized representative prior to care plan implementation (2.4). • Ensure member contact with the care management team occurs every 12 months or more based on stratification level (3.1). • Conduct a comprehensive care plan review at least once every 12 months (4.1). • Ensure member care plans are updated for changing needs (4.2). • Guarantee stratification levels are reassessed after a critical event (4.3). • Contact members within five business days of discharge from an inpatient hospital facility (5.1). • Ensure transitional care follow-up includes a review of hospital discharge information within the required timeframe (5.2).

Care Management Review
• Ensure monthly member face-to-face contact occurs with the Wisconsin Interdisciplinary Care Team (6.3).

MHS Health Wisconsin

The following results provide an overview of the SSI CMR for MHS.

Table 136. MHS Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Care Management Review
Strengths
• The organization ensured completed screens included all required elements (1.2). • The organization developed care plans that included all required elements (2.2). • The member or authorized representative agreed to the care plan prior to its implementation (2.4). • The organization reassessed members' stratification after a critical event (4.3).
Weaknesses/Opportunities for Improvement
• Member screens were not timely (1.1). • Care plans were not completed within the required timeframes (2.1). • Member care plans were not distributed to all required team members (2.3). • Members were not contacted once every 12 months or more based on their stratification level (3.1). • Follow-up was not timely for member needs (3.2). • Member care plans were not updated at least once every 12 months (4.1). • Member care plans were not updated for changing member needs (4.2). • Members were not contacted within five business days of discharge from an inpatient hospital facility (5.1). • Transitional care follow-up did not include a review of hospital discharge information with the member within the required timeframe (5.2).
Recommendations
• Complete member screens timely (1.1). • Complete care plans within the required timeframes (2.1). • Distribute care plans to all required team members (2.3). • Contact members once every 12 months or more based on their stratification level (3.1). • Provide timely follow-up for member needs (3.2). • Update the member care plan at least once every 12 months (4.1). • Update the member care plan for changing member needs (4.2). • Contact members within five business days of discharge from an inpatient hospital facility (5.1). • Ensure transitional care follow-up includes a review of hospital discharge information with the member within the required timeframe (5.2).

Molina Healthcare of Wisconsin

The following results provide an overview of the SSI CMR for MHWI.

Table 137. MHWI Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Care Management Review
Strengths
• The organization ensured member care plans were comprehensive (2.2). • The organization obtained agreement from the member or authorized representative prior to implementation of the care plan (2.4).
Weaknesses/Opportunities for Improvement
• Member screens were not timely (1.1). • Member screens were not comprehensive (1.2). • Care plans were not completed within the required timeframes (2.1). • Member care plans were not distributed to all required team members (2.3). • Members were not contacted once every 12 months or more based on their stratification level (3.1). • Follow-up was not timely for member needs (3.2). • Member care plans were not updated at least once every 12 months (4.1). • Care plans were not updated for changing member needs (4.2). • Members' stratification level was not assessed after a critical event (4.3). • Members were not contacted within five business days of discharge from an inpatient hospital facility (5.1). • Transitional care follow-up did not include a review of hospital discharge information with the member within the required timeframe (5.2).
Recommendations
• Ensure screens are completed timely (1.1). • Develop comprehensive screens (1.2). • Complete timely care plans (2.1). • Distribute care plans to all required people (2.3). • Contact members at least once every 12 months or more frequently based on stratification levels (3.1). • Address member follow-up needs timely (3.2). • Complete care plan reviews at least once every 12 months (4.1). • Update care plans for changing member needs (4.2). • Reassess the members' stratification level after a critical event (4.3). • Contact members within five business days of discharge from an inpatient hospital facility (5.1). • Complete transitional care follow-up of hospital discharge within the required timeframe (5.2).

Network Health Plan

The following results provide an overview of the SSI CMR for NHP.

Table 138. NHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Care Management Review
Strengths
• The organization developed screens that included all required elements (1.2). • The organization developed care plans that included all required elements (2.2). • The member or authorized representative agreed to the care plan prior to its implementation (2.4).
Weaknesses/Opportunities for Improvement
• Member screens were not timely (1.1). • Care plans were not completed within the required timeframes (2.1). • Member care plans were not distributed to all required team members (2.3). • Members were not contacted once every 12 months or more based on their stratification level (3.1). • Follow-up was not timely for member needs (3.2). • Member care plans were not updated at least once every 12 months (4.1). • Care plans were not updated for changing member needs (4.2). • Members' stratification level was not reassessed after a critical event (4.3). • Members were not contacted within five business days of discharge from an inpatient hospital facility (5.1). • Transitional care follow-up did not include a review of hospital discharge information with the member within the required timeframe (5.2).
Recommendations
• Conduct member screens timely (1.1). • Complete care plans within the required timeframes (2.1). • Distribute care plans to all required team members (2.3). • Ensure members are contacted once every 12 months or more based on their stratification (3.1). • Provide timely follow-up for member needs (3.2). • Update the member care plan at least once every 12 months (4.1). • Update the member care plan for changing member needs (4.2). • Reassess the members' stratification level after a critical event (4.3). • Contact members within five business days of discharge from an inpatient hospital facility (5.1). • Ensure transitional care follow-up includes a review of hospital discharge information with the member within the required timeframe (5.2).

Quartz Health Solutions, Inc.

The following results provide an overview of the SSI CMR for Quartz.

Table 139. Quartz Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Care Management Review
Strengths
• None identified.

Care Management Review
Weaknesses/Opportunities for Improvement
• Member screens were not timely (1.1). • Member screens were not comprehensive (1.2). • Care plans were not completed within the required timeframes (2.1). • Care plans were not comprehensive (2.2). • Member care plans were not distributed to all required people (2.3). • Care plan agreements were not obtained from the member or authorized representative prior to implementation (2.4). • Members were not contacted once every 12 months or more based on their stratification level (3.1). • Follow-up was not timely for member needs (3.2). • Member care plans were not updated at least once every 12 months (4.1). • Care plans were not updated for changing member needs (4.2). • Members' stratification level was not reassessed after a critical event (4.3). • Members were not contacted within five business days of discharge from an inpatient hospital facility (5.1). • Transitional care follow-up did not include a review of hospital discharge information with the member within the required timeframe (5.2).
Recommendations
• Conduct member screens timely (1.1). • Ensure screens include all required elements (1.2). • Complete care plans within the required timeframes (2.1). • Develop care plans that include all required elements (2.2). • Distribute the care plan to all required team members (2.3). • Obtain care plan agreement from the member or authorized representative (2.4). • Contact members once every 12 months or more based on their stratification level (3.1). • Ensure timely follow-up for member needs (3.2). • Update the member care plan at least once every 12 months (4.1). • Update the member care plan for changing member needs (4.2). • Ensure members' stratification is reassessed after a critical event (4.3). • Contact members within five business days of discharge from a hospital (5.1). • Ensure transitional care follow-up includes a review of hospital discharge information with the member within the required timeframe (5.2).

Security Health Plan of Wisconsin

The following results provide an overview of the SSI CMR for SHP.

Table 140. SHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Care Management Review
Strengths
• The organization developed care plans that included all required elements (2.2).

Care Management Review
• The organization shared the care plan with all required team members (2.3). • The member or authorized representative agreed to the care plan prior to its implementation (2.4). • The care management team addressed and provided timely follow-up of the members' needs (3.2).
Weaknesses/Opportunities for Improvement
• Member screens were not timely (1.1). • Member screens were not comprehensive (1.2). • Care plans were not completed within the required timeframes (2.1). • Members were not contacted once every 12 months or more based on their stratification level (3.1). • Member care plans were not updated at least once every 12 months (4.1). • Care plans were not updated for changing member needs (4.2). • Members' stratification level was not reassessed after a critical event (4.3). • Members were not contacted within five business days of discharge from an inpatient hospital facility (5.1). • Transitional care follow-up did not include a review of hospital discharge information with the member within the required timeframe (5.2).
Recommendations
• Conduct member screens timely (1.1). • Include all required elements in the screen (1.2). • Complete care plans within the required timeframes (2.1). • Ensure members are contacted once every 12 months or more based on their stratification level (3.1). • Update the member care plan at least once every 12 months (4.1). • Update the member care plan for changing member needs (4.2). • Ensure members' stratification is reassessed after a critical event (4.3). • Contact members within five business days of discharge from an inpatient hospital facility (5.1). • Ensure transitional care follow-up includes a review of hospital discharge information with the member within the required timeframe (5.2).

UnitedHealthcare Community Plan

The following results provide an overview of the SSI CMR for UHC.

Table 141. UHC Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

Care Management Review
Strengths
• The organization ensured the member or authorized representative agreed to the care plan prior to its implementation (2.4). • The care management team addressed and provided timely follow-up of the members' needs (3.2).
Weaknesses/Opportunities for Improvement
• Member screens were not timely (1.1). • Member screens were not comprehensive (1.2).

Care Management Review
• Care plans were not completed within the required timeframes (2.1). • Care plans were not comprehensive (2.2). • Member care plans were not distributed to all required team members (2.3). • Members were not contacted once every 12 months or more based on their stratification level (3.1). • Member care plans were not updated at least once every 12 months (4.1). • Care plans were not updated for changing member needs (4.2). • Members' stratification level was not reassessed after a critical event (4.3). • Members were not contacted within five business days of discharge from an inpatient hospital facility (5.1). • Transitional care follow-up did not include a review of hospital discharge information with the member within the required timeframe (5.2).
Recommendations
• Conduct member screens timely (1.1). • Include all required elements in the screen (1.2). • Complete care plans within the required timeframes (2.1). • Develop care plans that include all required elements (2.2). • Distribute the care plan to all required team members (2.3). • Ensure members are contacted once every 12 months or more based on their stratification level (3.1). • Update the member care plan at least once every 12 months (4.1). • Update the member care plan for changing member needs (4.2). • Ensure members' stratification is reassessed after a critical event (4.3). • Contact members within five business days of discharge from a hospital (5.1). • Ensure transitional care follow-up includes a review of hospital discharge information with the member within the required timeframe (5.2).

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 142. 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.

Degree	Description
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.

Table 143. State-Level Progress on Prior Recommendations

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
– Ensure member screens are completed timely (1.1). – Conduct comprehensive care planning by ensuring care plans are completed timely, are comprehensive, and are shared with all required individuals (2.2). – Provide strong care coordination by contacting members based on their needs and stratification level and providing timely and ongoing follow-up for members' needs (3.1). – Ensure care plans are reviewed and updated at least annually or when there is a change in members' needs (4.2). – Re-stratify members after each critical event (4.3). – Conduct timely and comprehensive transition planning for members discharging from an inpatient hospital setting (5.1). – Ensure the Wisconsin Interdisciplinary Care Team meets weekly to discuss members and has face-to-face monthly contact with members (6.2).	– The organizations improved coordination by contacting members based on their needs and stratification level and providing timely and ongoing follow-up for members' needs. However, improvements are still needed (3.1). – The organizations addressed and provided timely follow-up of the members' needs, however, improvements are still needed. (3.2).	Low

The table below identifies the recommendations made by the EQRO in the prior review, CY 2024, the actions taken by the organizations to address the recommendations, and the degree to which each addressed the recommendations.

Table 144. MCO-Level Progress

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Anthem	– Conduct timely screens (1.1). – Complete care plans within the required timeframes (2.1). – Include all required elements in the care plan (2.2). – Distribute care plans to all required team members (2.3). – Contact the member based on the member's stratification level (3.1). – Provide timely follow-up of identified member needs (3.2). – Update the member care plan at least once every 12 months (4.1). – Update the member care plan for changing member needs (4.2). – Ensure the member is re-stratified after a critical event (4.3). – Ensure timely transition planning following a hospitalization (5.1). – Complete timely transition care follow-up of hospital discharge information (5.2). – Include a minimum of two licensed health care providers in the Wisconsin	– The organization improved efforts completing the screen within the required timeframe; however, improvements are still needed (1.1). – The care management team improved efforts contacting and connecting with the member based on the assigned stratification level; however, improvements are still needed (3.1).	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	Interdisciplinary Care Core Team (6.1). – Ensure the Wisconsin Interdisciplinary Care Core Team meets at minimum weekly to discuss the member (6.2). – Have the Wisconsin Interdisciplinary Care Core Team conduct a once a month face-to-face visit with the member (6.3).		
GHC-EC	– Conduct timely screens (1.1). – Complete care plans within the required timeframes (2.1). – Ensure care plans are comprehensive (2.2). – Share the care plans with all required persons (2.3). – Contact the members based on their stratification levels (3.1). – Provide timely follow-up of identified member needs (3.2). – Update the member care plan at minimum once every 12 months (4.1). – Update the member care plan for changing member needs (4.2). – Ensure timely transition planning following a hospitalization (5.1). – Complete timely transition care follow-up of hospital discharge information (5.2).	– The organization improved efforts to complete care plans within the required timeframe; however, improvements are still needed (2.1). – The organization ensured care plans were comprehensive (2.2). – The organization improved efforts to share care plans with all required persons however, improvements are still needed (2.3). – The organization improved efforts contacting members based on assigned stratification level; however, improvements are still needed (3.1). – The organization provided timely follow-up of the member needs (3.2).	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Ensure the Wisconsin Interdisciplinary Care Team meets at least weekly to discuss the member (6.2). – Complete monthly face-to-face visits with the Wisconsin Interdisciplinary Care Team and member (6.3).		
*i*Care	– Conduct member screens timely (1.1). – Ensure screens include all required elements (1.2). – Complete care plans within the required timeframes (2.1). – Include all required elements in the care plan (2.2). – Distribute care plans to all required team members (2.3). – Ensure members are contacted once every 12 months or more based on their stratification (3.1). – Conduct a comprehensive care plan review at least once every 12 months (4.1). – Update the member care plan for changing member needs (4.2). – Ensure members are re-stratified after experiencing a critical event (4.3). – Contact members within five business days of discharge from an inpatient hospital facility (5.1).	– The organization ensured screens were comprehensive (1.2). – The organization improved efforts to ensure monthly member face-to-face contacts occurred with the Wisconsin Interdisciplinary Care Team; however, improvements are still needed (6.3).	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Ensure transitional care follow-up includes a review of hospital discharge information within the required timeframe (5.2). – Ensure the Wisconsin Interdisciplinary Care Team meets with members face-to-face once per month (6.3).		
MCHP	– Ensure the screens are completed timely (1.1). – Develop comprehensive screens (1.2). – Complete timely care plans (2.1). – Distribute care plans to all required persons (2.3). – Contact members at least once every 12 months or more frequently based on stratification levels (3.1). – Address follow-up needs timely (3.2). – Ensure care plans are reviewed once every 12 months (4.1). – Update the care plans for changing member needs (4.2). – Re-stratify members after a critical event (4.3). – Contact members within five business days of discharge from a hospital (5.1). – Complete transitional care follow-up of hospital discharge within the required timeframe (5.2).	– The organization improved its efforts to contact members every 12 months, or more frequently based on their assigned stratification level; however, further improvements are still needed. (3.1).	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
MHS	– Conduct member screens timely (1.1). – Complete care plans within the required timeframes (2.1). – Distribute care plans to all required team members (2.3). – Ensure members are contacted once every 12 months or more based on their stratification (3.1). – Provide timely follow-up for member needs (3.2). – Update the member care plan at least once every 12 months (4.1). – Update the member care plan for changing member needs (4.2). – Ensure members are re-stratified after experiencing a critical event (4.3). – Contact members within five business days of discharge from a hospital (5.1). – Ensure transitional care follow-up includes a review of hospital discharge information with the member within the required timeframe (5.2). – Ensure the Wisconsin Interdisciplinary Care Team meets with members face-to-face once per month (6.3).	– The organization did not address the prior review's recommendations.	Low
NHP	– Conduct member screens timely (1.1).	– The organization significantly increased contact with members	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Complete care plans within the required timeframes (2.1). – Ensure members are contacted once every 12 months or more based on their stratification (3.1). – Provide timely follow-up for member needs (3.2). – Review the member care plan at least once every 12 months (4.1). – Update the member care plan for changing member needs (4.2). – Ensure members are re-stratified after experiencing a critical event (4.3). – Contact members within five business days of discharge from a hospital (5.1). – Ensure transitional care follow-up includes a review of hospital discharge information within the required timeframe (5.2).	based on each member's stratification level (3.1). – The organization significantly increased follow-up for member needs and requests (3.2).	
Quartz	– Conduct timely screens (1.1). – Complete comprehensive screens (1.2). – Conduct timely care plans (2.1). – Complete comprehensive care plans (2.2). – Share care plans with all required individuals (2.3). – Ensure member care plan agreement prior to implementation (2.4).	– The member or authorized representative agreed to the care plan prior to its implementation (2.4); however, improvements are still needed. – The care management team contacted the member once every 12 months or more frequently based on the member's stratification level (3.1); however, improvements are still needed.	

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	– Contact members based on the assigned stratification level (3.1). – Update care plans at least once every 12 months (4.1). – Contact members within five business days of hospitalization discharge (5.1). – Ensure transition care follow-up occurs when contacting members after hospitalization discharge (5.2).		
SHP	– Conduct member screens timely (1.1). – Complete care plans within the required timeframes (2.1). – Ensure members are contacted once every twelve months or more based on their stratification (3.1). – Provide timely follow-up for member needs (3.2). – Update the member care plan at least once every twelve months (4.1). – Update the member care plan for changing member needs (4.2). – Ensure members are re-stratified after experiencing a critical event (4.3). – Contact members within five business days of discharge from a hospital (5.1). – Ensure transitional care follow-up includes a review of hospital	– The organization improved efforts contacting and connecting with members based on the assigned stratification level; however, improvements are still needed (3.1). – The organization significantly improved timely follow-up of members' needs and requests (3.2). – The organization increased stratification reassessment practices when members experienced a critical event; however, improvements are still needed (4.3).	Low

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
	discharge information within the required timeframe (5.2).		
UHC	– Conduct timely screens (1.1). – Complete care plans within the required timeframes (2.1). Share the care plans with all required persons (2.3). – Contact the member based on the member's stratification level (3.1). – Provide timely follow-up of identified member needs (3.2). – Update the member care plan at least once every 12 months (4.1). – Update the member care plan for changing member needs (4.2). – Ensure the member is re-stratified after a critical event (4.3). – Ensure timely transition planning following a hospitalization (5.1). – Complete timely transition care follow-up of hospital discharge information (5.2).	– The organization demonstrated timely follow-up to identified member needs (3.2).	Low

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

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 SSI CMR review methodology.

The information collected during the CMR is used to evaluate the accessibility, timeliness, quality, and appropriateness of care provided by MCOs and PIHPs to their members. CMR activities and findings contribute to DHS' broader strategy for assuring the CMS of the quality of services delivered. The Foster Care Medical Home Program, known as Care4Kids, collaborates with local child welfare agencies to deliver a medical model of care management tailored to the unique needs of children in out-of-home care. This program emphasizes coordinated and comprehensive health care, aiming to improve physical and mental health outcomes, foster resilience, and strengthen natural support systems for children during their placement.

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

Screening

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

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

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

- Newborns detained directly from the hospital;
- Children detained during an inpatient hospitalization;
- Children who are detained at the time of a forensic exam;
- Children who are detained subsequent to a forensic exam but meet the criteria for an exemption; or,

- Other unique case scenarios may be reviewed by the Care4Kids Medical Director(s) and exemptions may be granted on a case by case basis if performing the Out-of-Home Care Health Screen would be duplicative of services recently provided.

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

Care Planning
The initial care plan must be completed within the first 60 calendar days of enrollment. Ongoing care plans must be reviewed and updated at least once every six months, when indicated, and within 30 days of discharge from an inpatient mental health hospitalization. The care plan review must include the child, Primary Care Provider, OHC provider(s), parent/legal guardian, and child welfare case worker. A comprehensive care plan is evident when all required elements are documented.

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

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

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 is being evaluated or what the measure is intended to ensure.

Table 145. CMR Review Tool

Indicator	Indicator Label	Indicator Description
1.1	The Out-of-Home (OHC) Health Screen was completed within two business days of entry into out-of-home care	Measures whether the initial health screen was completed within two business days of a member's entry into out-of-home care, ensuring prompt identification of urgent health needs.

Indicator	Indicator Label	Indicator Description
		The member may be exempt from the OHC Health Screen for reasons defined in the DHS-FCMH contract. Only applicable to members who newly enrolled in the C4K program during the review period.
1.2	The Out-of-Home Care (OHC) Health Screen was comprehensive	Assesses whether the health screen addressed all required domains, including physical, behavioral, dental, and developmental health. The member may be exempt from the OHC Health Screen for reasons defined in the DHS-FCMH contract. Only applicable to members who newly enrolled in the C4K program during the review period.
2.1	The initial health assessment was completed within 30 days of enrollment	Evaluates whether a full health assessment was completed within 30 days of enrollment in the C4K program, applicable only to newly enrolled members.
2.2	The initial health assessment was comprehensive	Determines whether the assessment included all necessary components to inform care planning, such as medical history, current conditions, and behavioral health status. Only applicable to members who newly enrolled in the C4K program during the review period.
3.1	The initial care plan was developed within 60 days of enrollment	Measures whether the initial care plan was developed within 60 days of enrollment, ensuring timely coordination of services. Only applicable to members who newly enrolled in the C4K program during the review period.
3.2	The care plan was reviewed and updated at least once every six months or earlier when indicated	Assesses whether the care plan was reviewed and updated at least every six months or sooner if changes in the member's condition warranted it.
3.3	The care plan was reviewed and updated within 30 days of discharge from an inpatient mental health hospitalization	Evaluates whether the care plan was reviewed and updated within 30 days following discharge from an inpatient mental health hospitalization. Only applicable to members who experience a hospitalization during the review period.

Indicator	Indicator Label	Indicator Description
3.4	The most recent care plan review included input from the required individuals	Determines whether the most recent care plan review included input from all required stakeholders, such as the member, caregiver, and case manager. Only applicable to members who have an active care plan during the review period.
3.5	The most recent care plan was comprehensive	Assesses whether the care plan addressed all relevant domains and included actionable goals and interventions. Only applicable to members who have an active care plan during the review period.
4.1	Ongoing and timely monitoring and follow-up of the member's needs and services occurred	Evaluates whether the member's needs and services were consistently monitored and followed up on in a timely manner to ensure continuity of care.
5.1	The initial transition plan was created timely	Measures whether a transition plan was created at the same time as the initial comprehensive care plan. Only applicable to members who newly enrolled in the C4K program during the review period.
5.2	The transition plan was reviewed and updated at least once every six months	Assesses whether the transition plan was reviewed and updated at least every six months to reflect current needs and goals.
5.3	The most recent transition plan review included input from the required individuals	Determines whether the most recent transition plan review included input from all required stakeholders. Only applicable to members who have an active transition plan during the review period.
5.4	The most recent transition plan was comprehensive	Evaluates whether the transition plan addressed all relevant aspects of the member's transition, including health, education, and support services. Only applicable to members who have an active transition plan during the review period.

Care Management Review – Results

This report addresses the evaluation of care management practices for the review period of March 1, 2025 – August 31, 2025, with review conducted in CY 2025. Sample size for the review is determined prior to the start of the review. Records were randomly selected from an enrollment file provided by DHS. For details on the sampling methodology, please refer to Appendix 1.

The table below outlines both the current and prior two review cycles, along with the corresponding review period and sample sizes for each.

Table 146. CMR

Review	Review Period	Sample Size
CY 2023	March 1, 2023 – August 31, 2023	100
CY 2024	March 1, 2024 – August 31, 2024	126
CY 2025	March 1, 2025 – August 31, 2025	155

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

Table 147. CMR 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

CCHP's compliance score was 77.0 percent, and a compliance rating of Partially Met. The definition of an indicator rated as compliant can be found in Appendix 1 which includes the full implementation of contract required care management practices.

The following table presents the percentage and compliance rating achieved for the current review.

Table 148. CMR Results

Indicator	Indicator Label	CY 2025 Percentage Score	Compliance Rating
1.1	The Out-of-Home (OHC) Health Screen was completed within two business days of entry into out-of-home care	46.7%	Not Met
1.2	The Out-of-Home Care (OHC) Health Screen was comprehensive	100.0%	Fully Met
2.1	The initial health assessment was completed within 30 days of enrollment	61.9%	Minimally Met
2.2	The initial health assessment was comprehensive	73.7%	Partially Met
3.1	The initial care plan was developed within 60 days of enrollment	100.0%	Fully Met
3.2	The care plan was reviewed and updated at least once every six months or earlier when indicated	96.3%	Fully Met
3.3	The care plan was reviewed and updated within 30 days of discharge from an inpatient mental health hospitalization	0.0%	Not Met
3.4	The most recent care plan review included input from the required individuals	42.9%	Not Met
3.5	The most recent care plan was comprehensive	96.8%	Fully Met
4.1	Ongoing and timely monitoring and follow-up of the member's needs and services occurred	70.3%	Partially Met
5.1	The initial transition plan was created timely	100.0%	Fully Met
5.2	The transition plan was reviewed and updated at least once every six months	96.3%	Fully Met
5.3	The most recent transition plan review included input from the required individuals	42.9%	Not Met
5.4	The most recent transition plan was comprehensive	96.8%	Fully 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 review 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 shows the percentage scores from the current and previous reviews, along with the direction of change, which compares the two most recent review cycles, CY 2024 and CY 2025.

Table 149. CMR Comparative Results

Indicator	Indicator Label	CY 2023 Percentage Score	CY 2024 Percentage Score	CY 2025 Percentage Score	Change
1.1	The Out-of-Home (OHC) Health Screen was completed within two business days of entry into out-of-home care	100.0%	57.1%	46.7%	NS
1.2	The Out-of-Home Care (OHC) Health Screen was comprehensive	100.0%	100.0%	100.0%	NS
2.1	The initial health assessment was completed within 30 days of enrollment	52.2%	66.7%	61.9%	NS
2.2	The initial health assessment was comprehensive	50.0%	100.0%	73.7%	NS
3.1	The initial care plan was developed within 60 days of enrollment	100.0%	90.0%	100.0%	NS
3.2	The care plan was reviewed and updated at least once every six months or earlier when indicated	98.8%	99.1%	96.3%	NS
3.3	The care plan was reviewed and updated within 30 days of discharge from an inpatient mental health hospitalization	NA	0.0%	0.0%	NS

Indicator	Indicator Label	CY 2023 Percentage Score	CY 2024 Percentage Score	CY 2025 Percentage Score	Change
3.4	The most recent care plan review included input from the required individuals	24.0%	34.9%	42.9%	NS
3.5	The most recent care plan was comprehensive	97.0%	99.2%	96.8%	NS
4.1	Ongoing and timely monitoring and follow-up of the member's needs and services occurred	84.0%	77.0%	70.3%	NS
5.1	The initial transition plan was created timely	0.0%	100.0%	100.0%	NS
5.2	The transition plan was reviewed and updated at least once every six months	3.0%	100.0%	96.3%	▼
5.3	The most recent transition plan review included input from the required individuals	0.0%	34.9%	42.9%	NS
5.4	The most recent transition plan was comprehensive	0.0%	100.0%	96.8%	▼

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

For additional context and a deeper understanding of each score, readers are encouraged to reference both the aggregate data reports and the member-level reports. These resources provide detailed insights into care management performance, including specific metrics and member-level nuances that support the findings presented in this summary.

Care Plan Input

Engaging youth and caregivers in care planning is a foundational element of effective care management within the FCMH program. Given the unique needs and circumstances of children and youth in foster care, meaningful input from both the member and their caregiver is essential to developing a care plan that is responsive, trauma-informed, and aligned with the member's goals. However, care teams often face significant barriers to obtaining this input, including placement instability, limited caregiver availability, and challenges in coordinating

across systems. These factors can delay or prevent the completion of care planning activities, impacting the quality and continuity of care.

To better understand and address the challenges of engaging youth and caregivers in care planning, MetaStar introduced a focused measure based on the MY2025 FCMH Quality Guide, specifically targeting the Care Management Review Indicator, Care Plan Input. This measure is based on the CMR indicator 3.4, *The most recent care plan review included input from the required individuals*. The measure evaluates whether care plans reflect documented input from the member and/or caregiver, recognizing that their perspectives are essential to developing person-centered and actionable plans.

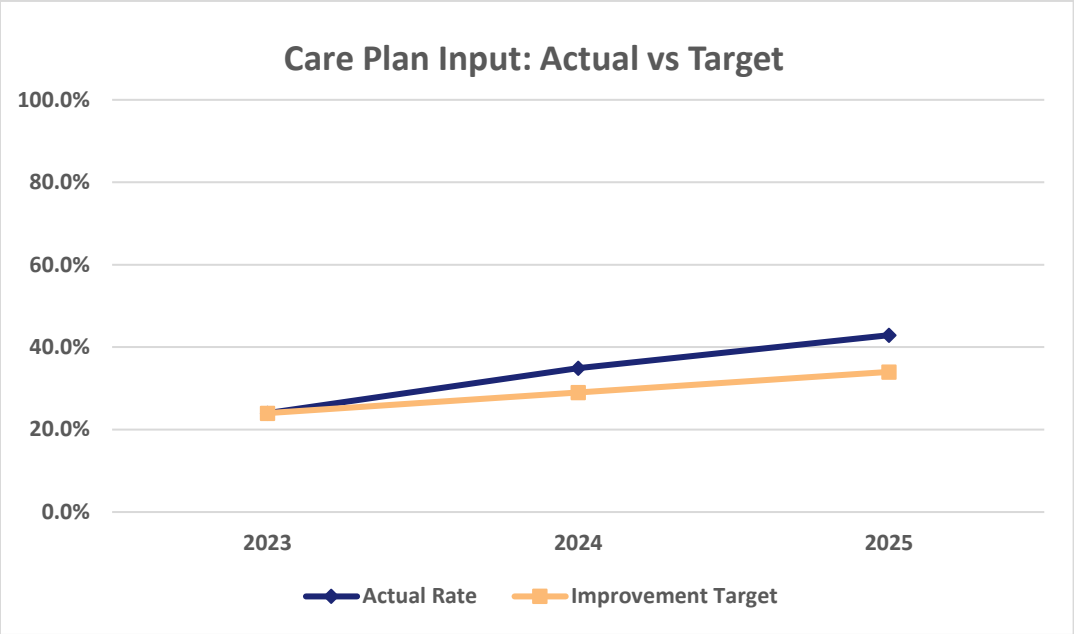
In alignment with DHS priorities, annual improvement targets were established to guide performance expectations and promote continuous quality improvement. These benchmarks serve as a reference point for evaluating progress and identifying areas where additional support or innovation may be needed. By comparing actual performance to DHS-established targets, the measure offers a clearer picture of how well care teams are meeting expectations and where further investment in engagement strategies may be warranted. The table below displays the rate achieved compared to the DHS improvement targets in the current and prior two years.

Table 150. Care Plan Input

Calendar Year	Actual Rate	Improvement Target	Improvement Target Outcome
2023	24.0%	24.0%	Met
2024	34.9%	29.0%	Met
2025	42.9%	34.0%	Met

The following chart illustrates annual performance of the Care Plan Input rate compared to the DHS Improvement Targets from 2023 through 2025. The visual trend highlights how actual performance has aligned with or deviated from the established benchmarks over time. This chart supports a clearer understanding of year-over-year progress and areas where additional support may be beneficial.

Chart 29. Care Plan Input: Actual vs Improvement Targets



Strengths, Weaknesses/Opportunities for Improvement and Recommendations

The following table identifies strengths, weaknesses/opportunities for improvement and recommendations for each area of practice reviewed. Strengths were given for care management practices that scored at or above 90 percent. Weaknesses, or opportunities for improvement, are included for any areas of practice that are below 90 percent. Additional opportunities for improvement may be included for practices that are minimally compliant. Recommendations are provided for all identified weaknesses and opportunities for improvement.

Table 151. CMR Strengths, Weaknesses/Opportunities for Improvement and Recommendations

CMR Strengths, Weaknesses/Opportunities for Improvement and Recommendations
Screening
Strengths: The PIHP demonstrated strong performance in ensuring the OHC Health Screens were comprehensive, reflecting thorough assessments of health conditions that require prompt medical attention, an unclothed, symptom targeted physical examination, including injury surveillance, and identification of medical treatment and follow up. These practices support early identification of concerns and promote continuity of care for members entering out-of-home placements.
Weaknesses/Opportunities for Improvement: Indicator 1.1 required the PIHP to complete the OHC Health Screen within two business days of out-of-home placement. The OHC Health Screen was

CMR Strengths, Weaknesses/Opportunities for Improvement and Recommendations
completed more than two business days from out-of-home placement in over half the records reviewed. *This scoring element is not met.*
Recommendations: Develop a process and tracking mechanism to ensure OHC Health Screens are conducted timely (1.1).
Assessment
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Indicator 2.1 required the PIHP to complete an initial health assessment within 30 days of enrollment. The initial health assessment was completed more than 30 days of enrollment in some records. *This scoring element is not met.* Indicator 2.2 required the initial health assessment to be comprehensive by addressing physical health, behavioral health, oral health, and developmental concerns. Records scored unmet for this indicator lacked an assessment of members' oral health needs. *This scoring element is not met.*
Recommendations: Develop a process and tracking mechanism to ensure initial health assessments are completed timely (2.1). Create procedures to ensure initial health assessments are comprehensive, including an evaluation of oral health needs (2.2).
Care Planning
Strengths: The PIHP demonstrated strong practices in care planning and review. Initial care plans were consistently developed within 60 days of enrollment, meeting timeliness standards. Ongoing reviews occurred at least every six months or sooner when indicated. The care plans were comprehensive, addressing the full scope of member needs and supporting coordinated, person-centered care.
Weaknesses/Opportunities for Improvement: Indicator 3.3 required the care plan to be reviewed and updated within 30 days of discharge from an inpatient mental health hospitalization. No records applicable to this indicator documented a care plan review and update with 30 days of discharge. *This scoring element is not met.* Indicator 3.4 required the most recent care plan to include input from all required individuals. The records scored not met commonly lacked input from the parent/legal guardian, child welfare case worker, OHC care provider, and the member, as appropriate, during the care plan timeframe. *This scoring element is not met.* As shown in Table 149, the actual rate for Care Plan Input exceeded DHS improvement targets for three consecutive years, indicating positive progress. However, the current rate of 42.9 percent remains well below the long-term goal of 90 percent, meaning significant gaps persist. Missing input from key individuals continues to be a common barrier, driven by factors such as placement instability, limited caregiver availability, and cross-system coordination challenges. Therefore, even with improvement trends, targeted strategies are needed to ensure care plans consistently reflect member and caregiver perspectives and move closer to full compliance.

CMR Strengths, Weaknesses/Opportunities for Improvement and Recommendations
Recommendations: Prioritize reviewing and updating care plans within 30 days of hospitalization discharge (3.3). Develop a process to obtain input from all required individuals into each care plan review (3.4).
Care Coordination
Strengths: None identified.
Weaknesses/Opportunities for Improvement: Indicator 4.1 required ongoing and timely monitoring and follow-up of members' needs and services. The records scored unmet were most often due to untimely follow-up of on-going dental or physical health needs. *This scoring element is not met.*
Recommendations: Create a procedure and tracking mechanism to ensure member needs and services receive appropriate follow-up every four to six weeks (4.1).
Transition Planning
Strengths: The PIHP demonstrated strong practices in transition planning. Initial transition plans were created in a timely manner, and ongoing reviews occurred at least every six months, ensuring plans remained relevant to members' evolving needs. Transition plans were comprehensive, supporting continuity of care and successful transitions across settings.
Weaknesses/Opportunities for Improvement: Indicator 5.3 required the most recent transition plan to include input from all required individuals. The records scored not met commonly lacked input from the parent/legal guardian, child welfare case worker, OHC care provider, and the member, as appropriate, during the transition plan timeframe. *This scoring element is not met.*
Recommendations: Develop a process to obtain input from all required individuals into each transition plan review (5.3).

Progress on Prior Recommendations

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

Table 152. Degree to Which Recommendations were Addressed

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.
NA	No recommendations received.

The tables below identify the recommendations made in the prior review, the actions taken to address the recommendations, and the degree to which the organization addressed the recommendations.

Table 153. Progress on Prior Recommendations

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
– Conduct timely out-of-home care health screens (1.1). – Ensure initial health assessments are completed timely (2.1). – Prioritize reviewing and updating care plans within 30 days of hospitalization discharge (3.3). – Include input from all required individuals into each care plan review (3.4). – Complete timely follow-up for member needs and services (4.1). – Include input from all required individuals into each transition plan review (5.3).	– No progress was identified.	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 and PIHP'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 and PIHPs 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/PIHP 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.

Under 42 CFR § 438.360, states may use results from private accreditation reviews in place of certain EQR activities, provided the standards are comparable to those outlined in 42 CFR § 438.358 and the CMS EQR protocols. MetaStar conducted a crosswalk comparing the requirements of the ISCA with those evaluated through the NCQA Health Plan Accreditation. This analysis confirmed that the accreditation review fully addresses all requirements outlined in Appendix A of the CMS EQR Protocol.

BC+ and SSI Medicaid managed care programs and PIHPs that are accredited through the NCQA Health Plan Accreditation receive an annual compliance audit conducted by a NCQA certified HEDIS® LO.

Each organization's annual HEDIS® audit, as well as the plan's ability to report HEDIS® measures, encompass the ISCA requirements. For organizations not evaluated by a NCQA certified HEDIS® LO, MetaStar conducts a full ISCA review. Below are the categories and standards established by NCQA that each MCO was evaluated for compliance with IS requirements.

Table 154. Information System Requirement Standards

Indicator	Indicator Label	Standards
IS R	Data Management and Reporting	5 Standards
IS C	Clinical and Care Delivery Data	4 Standards
IS M	Medical Record Review Processes	5 Standards
IS A	Administrative Data	3 Standards

A copy of each plan's FAR was obtained to confirm compliance. Validation of information systems was conducted for the following organizations in MY 2024.

Table 155. MCO HEDIS Compliance Audits

Organizations	Program(s)	HEDIS® Compliance Audit™
Anthem	BC+ SSI	HEDIS® LO: Attest Health Care Advisors FAR Date: July 15, 2025
CCF	Children with mental health needs	The organization received a full ISCA review in CY 2021. The organization ceased program operations in CY 2024 prior to an ISCA being conducted.
CCHP	BC+ FCMH	HEDIS® LO: HealthcareData Company, LLC FAR Date: July 10, 2025
DHP	BC+	HEDIS® LO: Attest Health Care Advisors FAR Date: July 15, 2025
GHC-EC	BC+ SSI	HEDIS® LO: HealthcareData Company, LLC FAR Date: July 2, 2025
GHC-SCW	BC+	HEDIS® LO: Advent Advisory Group FAR Date: June 16, 2025
*i*Care	BC+ SSI	HEDIS® LO: Dunwoody Technology Services Group, LLC FAR Date: July 15, 2025
MCHP	BC+	HEDIS® LO: Health Services Advisory Group FAR Date: July 15, 2025
MHS	BC+ SSI	HEDIS® LO: Attest Health Care Advisors FAR Date: July 15, 2025
MHWI	BC+ SSI	HEDIS® LO: Advent Advisory Group FAR Date: June 16, 2025
NHP	BC+ SSI	HEDIS® LO: Attest Health Care Advisors FAR Date: July 15, 2025
Quartz	BC+ SSI	HEDIS® LO: Advent Advisory Group FAR Date: June 16, 2025
SHP	BC+ SSI	HEDIS® LO: HealthcareData Company, LLC FAR Date: July 2, 2025
UHC	BC+ SSI	HEDIS® LO: Attest Health Care Advisors FAR Date: July 15, 2025

Organizations	Program(s)	HEDIS® Compliance Audit™
WM	Children with mental health needs	The organization received a full ISCA review in CY 2021. The organization ceased program operations in CY 2024 prior to an ISCA being conducted.

Information Systems Capabilities Assessment – Results

This report addresses the information systems requirements for the MCOs, and programs evaluated in CY 2025. The ISCA results provided insight into each MCO's/PIHP's capacity to collect, manage, and report data, supporting the evaluation of compliance and performance across multiple areas.

The following table identifies compliance ratings for the ISCA.

Table 156. Scoring Legend

Compliance Rating	Compliance Description
Met	The organization met all requirements.
Partially Met	The organization met most requirements.
Not Met	The organization did not meet requirements.

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

Table 157. ISCA Results

MCO	IS R	IS C	IS M	IS A
Anthem	Met	Met	Met	Met
CCHP	Met	Met	Met	Met
DHP	Met	Met	Met	Met
GHC-EC	Met	Met	Met	Met
GHC-SCW	Met	Met	Met	Met
*i*Care	Met	Met	Met	Met
MCHP	Met	Met	Met	Met
MHS	Met	Met	Met	Met
MHWI	Met	Met	Met	Met
NHP	Met	Met	Met	Met
Quartz	Met	Met	Met	Met
SHP	Met	Met	Met	Met

MCO	IS R	IS C	IS M	IS A
UHC	Met	Met	Met	Met

Information Systems Capabilities Assessment - State Level Findings

The table below identifies strengths, weaknesses/opportunities for improvement, and recommendations for each standard reviewed. Strengths were given for categories scored as Met. Weaknesses, or opportunities for improvement, are included for categories scored as Partially Met or Not Met. Recommendations are provided for all identified weaknesses and opportunities for improvement.

Table 158. ISCA Strengths, Weaknesses/Opportunities for Improvement and Recommendations

ISCA Strengths, Weaknesses/Opportunities for Improvement and Recommendations
IS R: Data Management and Reporting
Strengths: • The organizations maintained data management systems for both the plans and vendors that effectively enable performance measurement. • All standards for data extraction, loading, transformation, and integration were met with no identified adverse impacts. • The organizations successfully integrated data quality and governance into management processes. • Rigorous oversight and controls were in place to ensure the correct implementation of measure reporting software. • The organizations have established cybersecurity practices that promote the protection and resiliency of systems and data used for measurement.
Weaknesses/Opportunities for Improvement: None identified.
Recommendations: None identified.
IS C: Clinical and Care Delivery Data
Strengths: • The organizations met all standards for complete data capture across its clinical systems. • Clinical data conformed to industry standards, ensuring transaction files are accurate and valid. • The organizations effectively confirmed that ingested data meets established expectations for data quality, resulting in no adverse impacts
• **Weaknesses/Opportunities for Improvement:** None identified.
• **Recommendations:** None identified.

ISCA Strengths, Weaknesses/Opportunities for Improvement and Recommendations
IS M: Medical Record Review Process
Strengths: • Data collection forms successfully captured all fields relevant to measure reporting. • The retrieval and abstraction of data from medical records were performed reliably and accurately. • Electronic transmission procedures conformed to industry standards with sufficient checking procedures, such as logs and counts, to ensure data accuracy. • The organizations continually assessed data completeness and regularly monitored vendor performance against expected standards.
• **Weaknesses/Opportunities for Improvement:** None identified.
• **Recommendations:** None identified.
IS A: Administrative Data
IS A: Administrative Data
Strengths: • Data across claims, enrollment, provider, and vendor systems conformed to all industry standards and measure requirements. • Administrative data was found to be complete and accurate across all audited platforms. • The membership information systems are fully capable of enabling accurate measurement.
• **Weaknesses/Opportunities for Improvement:** None identified.
• **Recommendations:** None identified.

Information Systems Capabilities Assessment – Managed Care Organization Level Findings

Anthem Blue Cross and Blue Shield Health Plan

The following results provide an overview of the ISCA for Anthem.

Table 159. Anthem Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness.

ISCA
• Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Chorus Community Health Plan

The following results provide an overview of the ISCA for CCHP and Care4Kids.

Table 160. CCHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness. • Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Dean Health Plan, Inc.

The following results provide an overview of the ISCA for DHP.

Table 161. DHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness.

ISCA
• Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Group Health Cooperative of Eau Claire

The following results provide an overview of the ISCA for GHC-EC.

Table 162. GHC-EC Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness. • Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Group Health Cooperative of South-Central Wisconsin

The following results provide an overview of the ISCA for GHC-SCW.

Table 163. GHC-SCW Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness.

ISCA
• Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Independent Care Health Plan

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

Table 164. *i*Care Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness. • Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

MercyCare Health Plans

The following results provide an overview of the ISCA for MCHP.

Table 165. MCHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness.

ISCA
• Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

MHS Health Wisconsin

The following results provide an overview of the ISCA for MHS.

Table 166. MHS Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness. • Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Molina Healthcare of Wisconsin

The following results provide an overview of the ISCA for MHWI.

Table 167. MHWI Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness.

ISCA
• Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Network Health Plan

The following results provide an overview of the ISCA for NHP.

Table 168. NHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness. • Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Quartz Health Solutions, Inc.

The following results provide an overview of the ISCA for Quartz.

Table 169. Quartz Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness.

ISCA
• Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

Security Health Plan of Wisconsin

The following results provide an overview of the ISCA for SHP.

Table 170. SHP Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness. • Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
Weaknesses/Opportunities for Improvement
• None identified.
Recommendations
• None identified.

UnitedHealthcare Community Plan

The following results provide an overview of the ISCA for UHC.

Table 171. UHC Strengths, Weaknesses/Opportunities for Improvement, and Recommendations

ISCA
Strengths
• The organization maintained robust data management, governance, and cybersecurity practices that ensured accurate extraction, integration, and oversight of measure reporting software. • Clinical data capture and ingestion processes are fully compliant with industry standards, ensuring the accuracy and integrity of transaction files. • Medical record processes reliably captured all relevant fields and utilized secure, accurate abstraction and entry procedures to ensure data completeness.

ISCA
• Claims, enrollment, and provider data systems were complete and accurate, meeting all HEDIS® specifications for membership measurement.
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 172. 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 organizations addressed the recommendations.

Table 173. State-Level Progress

Previous EQR Recommendation(s)	Action(s) Taken	Degree Addressed
All organizations fully met requirements. No recommendations were identified.	N/A	N/A

The following table identifies the recommendations made in the prior review, CY 2024, the actions taken by the MCOs/PIHPs to address the recommendations; and the degree to which the MCOs/PIHPs addressed the recommendations.

Table 174. MCO-Level Progress

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
Anthem	The organization fully met all requirements. No recommendations were identified.	N/A	N/A
CCHP	The organization fully met all requirements. No recommendations were identified.	N/A	N/A
DHP	The organization fully met all requirements. No recommendations were identified.	N/A	N/A
GHC-EC	The organization fully met all requirements. No recommendations were identified.	N/A	N/A
GHC-SCW	The organization fully met all requirements. No recommendations were identified.	N/A	N/A
*i*Care	The organization fully met all requirements. No recommendations were identified.	N/A	N/A
MCHP	The organization fully met all requirements. No recommendations were identified.	N/A	N/A
MHS	The organization fully met all requirements. No recommendations were identified.	N/A	N/A
MHWI	The organization fully met all requirements. No recommendations were identified.	N/A	N/A

MCO	Previous Year's EQR Recommendation(s)	Action(s) Taken	Degree Addressed
NHP	The organization fully met all requirements. No recommendations were identified.	N/A	N/A
Quartz	The organization fully met all requirements. No recommendations were identified.	N/A	N/A
SHP	The organization fully met all requirements. No recommendations were identified.	N/A	N/A
UHC	The organization fully met all requirements. No recommendations were identified.	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 (CCBHC) 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 member subgroups, provider sites, or MCOs.
7.7 PIP results and findings were presented in a concise and easily understood manner.

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., member 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.*

The methodology for determining whether an improvement is statistically significant depends on whether the measure is a HEDIS® measure. For HEDIS® measures, the HEDIS® Bias Determination methodology is applied to assess significance. Using HEDIS® Bias Determinations to assess rate changes ensures that observed differences are statistically significant and not due to random variation. This method provides a consistent, standardized approach aligned with NCQA guidelines.

When a rate change falls within the established threshold for a given measure, it is considered not statistically significant. This suggests that the observed change is likely attributable to normal variation or chance, rather than a true shift in performance. Conversely, when a rate change falls outside the threshold, it is deemed statistically significant, indicating a high likelihood that the change reflects a real difference in performance. If the significant change represents an improvement, the methodology supports a high level of confidence in the statistical validity of that improvement. Because these determinations are based on final rates, the underlying data is considered valid and reliable, further reinforcing the credibility of the findings.

For projects that did not utilize a HEDIS® measure, 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.

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

Findings were initially compiled into a preliminary report. The organization had the opportunity to review prior to finalization of 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
This activity begins with defining the scope of validation to clarify review objectives. The team then assesses the integrity of the MCO's information system to ensure it can produce reliable performance data. Once confirmed, a detailed review of performance measures follows, including methodology, data sources, and calculations.

Activity 2: Conduct Validation
Under CMS Protocol and 42 CFR § 438.360, states may require MCOs to report their own performance measures or use a third party. States may also rely on private accreditation reviews if they meet EQR standards (42 CFR § 438.358). DHS uses NCQA HEDIS® measures, which are standardized and validated by certified NCQA HEDIS® auditors. MetaStar did not validate the measures but analyzed reported results.

MetaStar compared state performance to national benchmarks from NCQA's *Quality Compass®*, which includes data from NCQA-accredited Medicaid MCOs. These benchmarks reflect averages of reporting plans, not a true national average, and include states with and without Medicaid expansion.

Data sources for validation**:**

- FAR reports from HEDIS Compliance Audit™
- Numerator and denominator data for each measure
- NCQA *Quality Compass® 2023*

Activity 3: Analysis and Reporting
This activity finalizes validation by determining preliminary findings for each measure. Compliance is expressed as a percentage and rated accordingly. HEDIS® MY 2024 data, reported in CY 2025, was used for analysis. MetaStar compared the State's performance on national

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

Rates are expressed as percentages, which represent the proportion of eligible members who received the recommended service or met the measure criteria. For example, a rate of 49 percent means that 49 out of every 100 eligible children received lead screening. Ideally, rates should approach 100 percent, indicating full compliance with the measure.

In contrast, national benchmarks are expressed as percentiles, which indicate how a health plan's performance compares to other reporting plans nationwide. Percentiles do not reflect the actual percentage of compliance but rather the relative ranking among peers. For example:

- 50th percentile: The plan performed as well as or better than 50 percent of all reporting plans.
- 75th percentile: The plan performed better than at least 75 percent of reporting plans.

This distinction is important:

- Percentages measure absolute performance (how many members received the service).
- Percentiles measure relative performance (how the plan compares to others).

These benchmarks help identify areas for improvement. Plans below the 50th percentile show significant room for growth, while those above the 75th percentile may prioritize other measures.

Due to licensing restrictions with NCQA, only a limited number of benchmarks can be published each year. For this analysis, the selected benchmarks are the national 50th percentile and 75th percentile. Strengths from the performance measure validation are defined as quality indicator rates at or above the 75th percentile. Weaknesses, or opportunities for improvement, are included for any quality indicator rate that is below the 50th percentile. Recommendations are provided for all identified weaknesses and opportunities for improvement.

Performance falling between the 50th and 74th percentiles is classified as compliant. These measures will not be formally identified as strengths or weaknesses/opportunities for improvement. While these measures meet standard requirements, current outreach and clinical workflows should be maintained to drive performance toward the 75th percentile benchmark. These benchmarks are used to categorize each MCO's performance into three levels identified in the table below.

National Benchmark	Result	Meaning
Above 75th Percentile	Strength	The MCOs are performing better than most others nationally.
50th - 75th Percentile	Compliant	The MCOs meet acceptable standards but have room for improvement.
Below 50th Percentile	Opportunity	The MCOs are underperforming compared to peers and may need targeted support.

This rating system helps identify where MCOs excel, meet expectations, or require improvement. It also supports prioritizing quality improvement efforts based on comparative performance.

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

Compliance with Standards Review is a required EQR activity, and 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.

The Wisconsin Department of Health Services and MetaStar completed the *Accreditation Crosswalk* (crosswalk) as part of *DHS's Accreditation Deeming Plan* in the *Managed Care Quality Strategy*. As instructed by CMS, the crosswalk is updated for requirement changes and at minimum every three years to align with the DHS Medicaid Managed Care Quality Strategy. The Managed Care Organization Accreditation Deeming Plan is updated to compare NCQA accreditation requirements with the federal Managed Care requirements for Medicaid MCOs (42 CFR § 438) in order to determine gaps between requirements.

The *Accreditation Deeming Plan* deems that a full Compliance with Standards review is duplicative for organizations with full NCQA Accreditation. The crosswalk compares the CFR Managed Care requirements to the NCQA accreditation standards, the DHS-MCO contract, and annual DHS Certification Application to identify gaps in assuring full compliance with the regulations. The crosswalk review assesses the strengths and opportunities for improvement of the MCO related to quality, timeliness, and access to services, including health care and members with special health care needs. MetaStar conducted a document review to evaluate policies, procedures, and practices within the organization. The review assessed information about the MCO's NCQA accreditation results, as well as its structure, operations, and practices related to the gaps identified through the crosswalk. The requirements were then connected to the Compliance with Standards focus areas and sub-categories to allow comparability in results across all MCOs, regardless of accreditation status.

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 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 the Medicaid Managed Care 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

Focus Area	Related Sub-Categories in Review Standards
	• Coverage and Authorization of Services - 42 CFR § 438.210 • Emergency and post-stabilization services 42 CFR § 438.114 • Provider Selection - 42 CFR § 438.214 • Confidentiality - 42 CFR § 438.224 • Subcontractual Relationships and Delegation - 42 CFR § 438.230 • Practice Guidelines - 42 CFR § 438.236 • Health Information Systems - 42 CFR § 438.242
Quality Assessment and Performance Improvement (QAPI) – **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 requested and reviewed additional documents, as needed, to clarify information gathered during the review.

Activity 3: MCO NCQA Accreditation Review

The evaluation process centers on a systematic "crosswalk" analysis where the EQRO maps NCQA accreditation standards against federal Medicaid requirements to identify overlapping criteria. Once the MCO provides its confidential NCQA Final Report, the EQRO analyzes specific scoring elements to determine if the accreditation review was sufficiently stringent to satisfy mandatory EQR activities. Standards identified as "Met" by NCQA are formally "deemed" compliant, allowing the EQRO to bypass redundant documentation reviews, while any "Partially Met" or "Not Met" findings are flagged as areas of non-compliance. Ultimately, this process streamlines the review by focusing the EQRO's primary audit efforts solely on "gap" areas, such as state-specific contractual mandates or federal requirements not addressed by NCQA, ensuring a comprehensive compliance picture without duplicating administrative work.

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 and a compliance rating that aligns with Protocol 3.

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 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 for FAR for NCQA Accreditation.
- 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.

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 – Supplemental Security Income

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

Activity 1: Establish Compliance Thresholds
The review team begins by gathering information from the state and defining benchmarks to guide the compliance assessment.

MetaStar's care management review tool and reviewer guidelines are based on DHS-MCO contract requirements and DHS-provided care management training. Reviewers are trained to use DHS-approved tools, guidelines, and the review database. In addition to identifying any immediate member health or safety concerns, MetaStar evaluates four key areas of care management practice:

- Screening
- Care Planning
- Care Coordination
- Wisconsin Interdisciplinary Care Team (WICT) structure and processes

Activity 2: Perform the Preliminary Review
Early contact is made with the MCO, and a document review is conducted to prepare for the review. MetaStar randomly selected a sample of member records. The random sample included a mix of members who enrolled during the last year, members who had been enrolled for more than 90 consecutive days, and members who had left the program since the sample was generated.

Prior to the Care Management Review, MetaStar reviews the MCO's policies and procedures to understand documentation practices.

Activity 3: MCO Review
This phase involves planning and conducting the review. Key steps include:

- Setting the review dates and duration.
- Determining reviewer roles and team composition.
- Developing the deliverables list and timeframes for review.

- Providing preparation guidance to the MCO.

During the review, MetaStar maintains contact with the MCO and provides updates as needed.

Activity 4: Compile and Analyze Findings

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 expressed 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

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

Activity 5: Report Results to the State
MetaStar submits a report outline, a final determination report, and any additional documentation requested by DHS, completing the review process.

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 9: Conducting Focused Studies of Health Care Quality – Foster Care Medical Home

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

Activity 1: Establish Compliance Thresholds
The review team begins by gathering information from the state and defining benchmarks to guide the compliance assessment.

MetaStar's care management review tool and reviewer guidelines are based on DHS-PIHP contract requirements and DHS-provided care management training. Reviewers are trained to use DHS-approved tools, guidelines, and the review database. In addition to identifying any immediate member health or safety concerns, MetaStar evaluates four key areas of care management practice:

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

Activity 2: Perform the Preliminary Review
During this phase of the review, early contact is established with the PIHP to facilitate planning and coordination. Key preparatory steps include:

- Establishing review dates and duration.
- Defining reviewer roles and team composition.
- Developing a list of deliverables and associated timelines.
- Providing guidance to the provider on how to prepare for the review.
- Conducting a preliminary review of provider policies and procedures.

At the start of each review, a sample size is determined using a 80 percent confidence level and a ±5 percent margin of error. Eligibility criteria are refined to include members who were enrolled in the Care4Kids program for at least 60 days during the review period. All sample sizes and related costs are reviewed and approved DHS prior to initiating the review.

A random sample is drawn from the pool of eligible records, which may include individuals who have since exited the program. The finalized sample is issued to the provider along with a record checklist that outlines the documentation required for each record to support the review process.

Activity 3: PIHP Review

Reviewers conduct each record review using the approved materials and guidelines to ensure consistency and accuracy. Throughout the process, MetaStar maintains ongoing communication with the organization under review, sharing updates and addressing questions as needed to support a smooth and transparent evaluation.

Activity 4: Compile and Analyze Findings

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

CMR compliance is expressed 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

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

Activity 5: Report Results to the State

MetaStar issues preliminary results to the PIHP, offering an opportunity to submit rescoring requests or clarifications. This step ensures transparency and allows the PIHP to address any discrepancies or concerns before results are finalized.

If concerns arise regarding a member's immediate health and safety, or if complex or challenging circumstances are identified, MetaStar communicates all situations to DHS and the PIHP.

At the conclusion of the record review, MetaStar provides both DHS and the PIHP with detailed findings from each individual record, along with a summary of the PIHP'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 four key activities.

Activity 1: MCO Completes the ISCA Tool

MetaStar collaborates with DHS to define expectations, scoring criteria, and compliance thresholds. Each non-accredited MCO completes a standardized ISCA tool detailing its data systems and capabilities.

MetaStar confirms that each MCO undergoes an annual HEDIS® Compliance Audit. For MCOs audited by an NCQA-certified HEDIS® LO, the audit results are used to satisfy ISCA requirements. If a MCO is not evaluated by an NCQA-certified HEDIS® LO, MetaStar conducts a full ISCA review.

Under 42 CFR § 438.360, states may substitute private accreditation reviews for certain EQR activities if standards align with 42 CFR § 438.358 and CMS protocols. MetaStar performed a crosswalk analysis confirming that NCQA Health Plan Accreditation meets all ISCA requirements.

MCOs participating in BadgerCare Plus and SSI Medicaid programs that are NCQA-accredited receive annual compliance audits from NCQA-certified HEDIS® LOs.

Per 42 CFR § 438.242, health information systems must:

- Collect enrollee and provider data and service information.
- Ensure data accuracy and completeness.
- Make data available to the State and CMS upon request.

Activity 2: Preliminary ISCA Review

MetaStar reviews the submitted ISCA tool or HEDIS® audit to identify areas needing clarification. Reviewers may also assess supplemental documentation, including vendor-provided sections, to evaluate systems used for claims and encounter data processing.

Activity 3: Compile and Analyze ISCA Findings

Findings from the ISCA tool and site visits are compiled and analyzed to assess each MCO's information system capabilities. Compliance is rated as:

Compliance Rating	Compliance Description
Met	The organization met all requirements.
Partially Met	The organization met most requirements.
Not Met	The organization did not meet requirements.

Activity 4: Draft ISCA Summary for EQR Technical Report

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

Progress on Prior Recommendations

Each activity 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** – Less than half of the 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® 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).

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 Clinical Aim Improvement Strategies

MCO	Topic	Clinical Improvement Strategies	Effectiveness
Anthem	Diabetic Care	Deployed community health workers at Sixteenth Street Community Health Center.	Not Effective
CCHP - C4K	Emergency Department Utilization	Completed staffing intervention for high emergency room utilizers.	Effective
CCHP	Childhood Immunization Status	Implemented targeted promotional campaigns to members with routine immunization care gaps.	Effective
CCHP	Childhood Immunization Status	Mailed educational materials to members focused on routine immunizations for infants.	Effective
CCHP	Childhood Immunization Status	Maintained a website containing information and education about pediatric preventative services focused on routine immunizations.	Effective
CCHP	Childhood Immunization Status	Provided educational materials to community members at community-based	Effective

MCO	Topic	Clinical Improvement Strategies	Effectiveness
		service locations and community health and wellness events.	
CCHP	Childhood Immunization Status	Mailed monthly reminders to all members aged three months to 20 years to schedule a HealthCheck appointment to receive recommended routine immunizations.	Effective
CCHP	Childhood Immunization Status	Sent monthly automated text message reminders about routine preventative care to all eligible members between the ages of 18-23 months and 11-12 years old.	Effective
CCHP	Childhood Immunization Status	Provided training on addressing preventative care, including routine immunizations, to all CCHP staff that engage with members.	Effective
CCHP	Childhood Immunization Status	Shared proactive HEDIS® reports with providers engaged in a VBR agreement with CCHP listing care gaps for their members.	Effective
CCHP	Childhood Immunization Status	Facilitated quarterly meetings with network provider groups engaged in a VBR agreement with CCHP to share data, outcomes, challenges, and opportunities related to HEDIS performance scores.	Effective
DHP	Prenatal and Postpartum Care	Partnered with Harambee Doula Care and Holistic Services for doula services.	Effective
DHP	Prenatal and Postpartum Care	Offered members the option to enroll in the DHP case management OBMH program.	Effective
DHP	Prenatal and Postpartum Care	Provided prenatal care education to the community.	Effective

MCO	Topic	Clinical Improvement Strategies	Effectiveness
GHC-EC	Follow-Up After Hospitalization for Mental Illness	Provided targeted outreach to educate members on the importance of follow-up care after hospitalization for mental illness.	Not Effective
GHC-EC	Follow-Up After Hospitalization for Mental Illness	Partnered with Vantage Point Clinic to offer members in-person or telehealth assessments to complete follow-up in a timely manner	Not Effective
GHC-SCW	Colorectal Cancer	Mailed Cologuard testing kits to members to encourage Colorectal cancer screening.	Effective
*i*Care	Comprehensive Diabetes Care	Conducted telephonic outreach and offered enrollment to Diabetic Education Program for members with HgA1c between 8% and 9%.	Effective
*i*Care	Comprehensive Diabetes Care	Mailed HgA1c educational flyer and reminder letter to all members due for an HbA1c blood test.	No Evaluation
*i*Care	Comprehensive Diabetes Care	Mailed notice of incomplete HgA1c blood draw reminder letter to all non-compliant members and their PCP.	Effective
MCHP	Childhood Immunization Status	Conducted monthly outreach calls to parents of children aged two to three months to share timely vaccine reminders and educational information.	No Evaluation
MCHP	Childhood Immunization Status	Partnered with a CBO to address SDoH barriers.	No Evaluation
MHS	Behavioral Health Disparities	Implemented a Behavioral Health – Community Health Worker to provide health coaching, care coordination, and social needs support to members.	Effective

MCO	Topic	Clinical Improvement Strategies	Effectiveness
MHS	Behavioral Health Disparities	Launched a suicide prevention program, Choose Tomorrow, and offered NeuroFlow, a digital phone application, to support mental wellness.	Effective
MHS	Behavioral Health Disparities	Partnered with Wisconsin Community Services to refer members to community-based behavioral health and substance use disorder services.	Effective
MHWI	Cervical Cancer	Distributed a mailer with trauma-informed care resources, information on cervical cancer screening, and transportation resources.	Effective
MHWI	Cervical Cancer	Provided case management support to develop goals regarding cervical cancer screening. Provided trauma-informed care staff training.	Effective
MHWI	Cervical Cancer	Offered an incentive to members who attested to completing cervical cancer screening.	Effective
MHWI	Cervical Cancer	Completed a call campaign.	Effective
MHWI	Cervical Cancer	Distributed a mailer informing members of an incentive to complete cervical cancer screening.	Effective
MHWI	Cervical Cancer	Provided cervical cancer screening reminders and information regarding an incentive via Relay text messages.	Effective
NHP	Prenatal and Postpartum Care	Offered a diaper incentive program to members.	Effective
NHP	Prenatal and Postpartum Care	Offered support via Baby Live Advice, a virtual education platform, to promote better health outcomes.	Effective

MCO	Topic	Clinical Improvement Strategies	Effectiveness
NHP	Prenatal and Postpartum Care	Provided a prenatal and postpartum food program to address food insecurity and healthy birth outcomes.	Effective
NHP	Prenatal and Postpartum Care	Partnered with community based BH and SUD service providers for a HUB and Spoke Program to connect pregnant members with services to support health and recovery.	Effective
Quartz	Comprehensive Diabetes Care	Offered enrollment to Quartz's Diabetes and Obesity Reversal Program.	Not Effective
Quartz	Comprehensive Diabetes Care	Conducted care management outreach to identified members.	Not Effective
SHP	Comprehensive Diabetes Care	Launched targeted educational mailings and email outreach.	Effective
SHP	Comprehensive Diabetes Care	Contracted with FindHelp, a social care platform to address social determinants of health.	Effective
UHC	Prenatal and Postpartum Care	Planned to partner with FarmBox RX to provide fresh food boxes to members experiencing food insecurity.	Not Implemented
UHC	Prenatal and Postpartum Care	Partnered UHCCP WI Maternity Field Based Community Health Workers with members to assist in care coordination and targeted service bundles based on member needs.	Effective
UHC	Prenatal and Postpartum Care	Connected members to a peer support group through Wellhop.	Effective
UHC	Prenatal and Postpartum Care	Provided Mom's Meals delivery to pregnant or postpartum members experiencing food insecurity.	Effective
UHC	Prenatal and Postpartum Care	Provided community-based Doulas to support members during pregnancy and postpartum.	Not Effective

MCO	Topic	Clinical Improvement Strategies	Effectiveness
UHC	Prenatal and Postpartum Care	Conducted a Drivers of Health Needs Assessment with members and provided community resources through FindHelp.	No Evaluation

MCO Non-Clinical Aim Improvement Strategies

MCO	Topic	Non-Clinical Improvement Strategies	Effectiveness
Anthem	Screening	Deployed community health workers at Kenosha Community Health Center.	Effective
CCHP – C4K	Birth to 3 Referral	Outreached to the parent/legal guardian within 30 days of identification of a positive developmental screen and provided DHS approved Birth to 3 information.	Effective
CCHP	Diabetic Care	Included member participation on the PIP team.	Not Implemented
CCHP	Diabetic Care	Provided high touch nurse care management outreach including SDoH screening and support.	Effective
CCHP	Diabetic Care	Monitored utilization of emergency department and inpatient services and offered care coordination and resources to members.	Not Effective
CCHP	Diabetic Care	Collaborated with providers and community partners to identify strategies to support member engagement with outpatient services.	Not Effective
DHP	Health Needs Assessment	Partnered with iCario to deploy a multi-faceted member outreach approach.	Not Implemented
DHP	Health Needs Assessment	Offered members a $25 gift card upon completion of the HNA.	Effective
DHP	Health Needs Assessment	Completed member outreach via DHP's Customer Service Call Center.	Effective

MCO	Topic	Non-Clinical Improvement Strategies	Effectiveness
DHP	Health Needs Assessment	Engaged health system partner, Sisters of Saint Mary Wisconsin clinics, to complete the HNA in the clinic setting.	Not Implemented
GHC-EC	Member Satisfaction	Administered a culturally and linguistically appropriate satisfaction survey to members.	Effective
GHC-EC	Member Satisfaction	Offered members alternative methods for survey completion.	Effective
GHC-SCW	Electronic Patient Portal	Sent postal mailings to members to encourage MyChart activation.	Effective
GHC-SCW	Electronic Patient Portal	Offered MyChart activation to new members during Health Needs Assessment calls.	Effective
GHC-SCW	Electronic Patient Portal	Conducted telephone outreach to members who were not established with a primary care provider.	Effective
GHC-SCW	Electronic Patient Portal	Entered a reminder for reception and nursing staff to offer MyChart activation for members with upcoming clinic visits.	Effective
*i*Care	AODA Services in Pregnancy	Implemented the WCS Hub and Spoke Maternal Program.	Not Effective
MCHP	Social Needs	Collected provider race/ethnicity data through electronic communication and surveys.	Not Effective
MCHP	Social Needs	Implemented marketing efforts on the organization's website to better inform members of how to request provider demographic information.	Not Effective
MHS - HMO	Health Needs Assessment	Provided targeted outreach to members, utilizing the NEST score, to complete an initial HNA.	Effective

MCO	Topic	Non-Clinical Improvement Strategies	Effectiveness
MHS	Health Needs Assessment	Optimized digital member outreach options, including online assessment capability and text messaging reminders.	Not Effective
MHS	Health Needs Assessment	Created and implemented the Roulette Tool to tailor outreach strategies, such as the use of primary language outreach with the first call to members.	Effective
MHWI	Member Satisfaction	Conducted an internal staff survey to identify barriers non-English speakers may face with interpreter services.	No Evaluation
MHWI	Member Satisfaction	Implemented the Member Concierge program.	No Evaluation
MHWI	Member Satisfaction	Distributed a member mailing to increase awareness of interpreter services.	No Evaluation
NHP	Social Determinants of Health	Utilized NEST scores to provide targeted outreach to members.	Effective
NHP	Social Determinants of Health	Obtained DOH screener result of NHP members through partnerships with health care providers.	Effective
NHP	Social Determinants of Health	Optimized the use of electronic DOH Screeners via the Find Help platform.	Effective
Quartz	Health Risk Assessment	Conducted increased telephonic outreach attempts.	No Evaluation
Quartz	Health Risk Assessment	Launched an online HRA completion Tool.	No Evaluation
Quartz	Health Risk Assessment	Offered a $25 gift card incentive for completion of the HRA.	No Evaluation
SHP	Care Management Engagement	Implemented FindHelp to address social determinants of health.	Effective

MCO	Topic	Non-Clinical Improvement Strategies	Effectiveness
SHP	Care Management Engagement	Utilized various methods of member outreach, including providing educational materials and assessments via text, paper, or through phone calls.	Effective
SHP	Care Management Engagement	Trained staff on culturally responsive care, navigation of social determinates of health, and person-centered approaches.	Effective
UHC	Food Insecurity Screening	Conducted phone outreach campaign to screen diabetic members in Milwaukee County for food insecurity and provided referrals when needed.	Effective
UHC	Food Insecurity Screening	Partnered with FarmBox RX to reach more members for screening as well as to provide fresh food to those with an identified need.	Not Implemented
UHC	Food Insecurity Screening	Partnered with Sherman Park Grocery to reach more members for screening and offered members a gift card for the grocery store.	No Evaluation
UHC	Food Insecurity Screening	Provided Mom's Meals to reach more members for engagement and screening as well as to provide fresh food to those with an identified need.	No Evaluation
UHC	Food Insecurity Screening	Incentivized member visits to Progressive Community Health Diabetes Center of Excellence with a grocery gift card.	No Evaluation
WM	Program Transition	Offered and conducted comprehensive rescreening for youth by Options Counselors.	No Evaluation
WM	Program Transition	Developed a web-based portal to allow youth, caregivers, and providers to ask questions and provide feedback regarding the disenrollment and transition process.	No Evaluation

MCO	Topic	Non-Clinical Improvement Strategies	Effectiveness
WM	Program Transition	Developed a centralized resource hub which included frequently asked questions, guidance documents, and service navigation tools.	No Evaluation

Appendix 3 – Compliance with Standards – Statewide and MCO Level Results

The tables below display the results from the standards reviewed in the CY 2024 review at the state and MCO level.

State Level Compliance with Standards Results – QAPI Standards

Standard	Scoring Elements	Percentage	Compliance Rating
Q1: General rules - 42 CFR § 438.330(a)	103/108	95.4%	Fully Met
Q2: Basic elements of the quality assessment and performance improvement program - 42 CFR § 438.330(b)	82/84	97.6%	Fully Met
Q3: Performance measurement - 42 CFR § 438.330(c)*	N/A	N/A	N/A
Q4: Performance improvement projects - 42 CFR § 438.330(d)*	N/A	N/A	N/A
Q5: QAPI evaluations review - 42 CFR § 438.330(e)(2)	34/48	70.8%	Partially Met
Overall	**219/240**	**91.3%**	**Fully Met**

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

State Level Compliance with Standards Results – Grievance Systems Standards

Standard	Scoring Elements	Percentage	Compliance Rating
G1: Grievance systems - 42 CFR § 438.228	58/60	96.7%	Fully Met
G2: General requirements - 42 CFR § 438.402	83/84	98.8%	Fully Met
G3: Timely and adequate notice of adverse benefit determination - 42 CFR § 438.404	106/120	88.3%	Substantially Met
G4: Handling of grievances and appeals - 42 CFR § 438.406	71/72	98.6%	Fully Met
G5: Resolution and notification - 42 CFR § 438.408	134/156	85.9%	Substantially Met
G6: Expedited resolution of appeals - 42 CFR § 438.410	30/36	83.3%	Substantially Met
G7: Information about grievance and appeal system to providers and subcontractors - 42 CFR § 438.414	8/24	33.3%	Not Met

Standard	Scoring Elements	Percentage	Compliance Rating
G8: Record keeping requirements - 42 CFR § 438.416	23/24	95.8%	Fully Met
G9: Continuation of benefits while the local appeal and the state Fair Hearing are pending - 42 CFR § 438.420	39/48	81.3%	Substantially Met
G10: Effectuation of reversed appeal resolution - 42 CFR § 438.424	23/24	95.8%	Fully Met
Overall	**575/648**	**88.7%**	**Substantially Met**

BC+ MCO Compliance with Standards Comparison Results – QAPI Standards

Standard	CCHP	DHP	GHC-SCW	MCHP
Q1: General rules - 42 CFR § 438.330(a)	100.0%	88.9%	100.0%	88.9%
Q2: Basic elements of the quality assessment and performance improvement program - 42 CFR § 438.330(b)	100.0%	100.0%	100.0%	100.0%
Q3: Performance measurement - 42 CFR § 438.330(c)*	N/A	N/A	N/A	N/A
Q4: Performance improvement projects - 42 CFR § 438.330(d)*	N/A	N/A	N/A	N/A
Q5: QAPI evaluations review - 42 CFR § 438.330(e)(2)	50.0%	75.0%	50.0%	50.0%

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

BC+ and SSI MCO Compliance with Standards Comparison Results – QAPI Standards

Standard	Anthem	GHC-EC**	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
Q1: General rules - 42 CFR § 438.330(a)	88.9%	100.0%	88.9%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%
Q2: Basic elements of the quality assessment and performance improvement program - 42	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	71.4%	100.0%	100.0%

Standard	Anthem	GHC-EC**	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
CFR § 438.330(b)									
Q3: Performance measurement - 42 CFR § 438.330(c)*	N/A	NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Q4: Performance improvement projects - 42 CFR § 438.330(d)*	N/A	NA	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Q5: QAPI evaluations review - 42 CFR § 438.330(e)(2)	75.0%	100.0%	50.0%	100.0%	50.0%	100.0%	50.0%	100.0%	100.0%

*Q3 and Q4 are evaluated as part of the organization's performance measure validation and performance improvement project validation. These reviews occur separately from the Compliance with Standards Review.
**GHC-EC's results are from a CY 2022 Compliance with Standards Review, which preceded its NCQA Accreditation in CY 2023.

BC+ MCO Compliance with Standards Comparison Results – Grievance System Standards

Standard	CCHP	DHP	GHC-SCW	MCHP
G1: Grievance systems - 42 CFR § 438.228	80.0%	100.0%	100.0%	100.0%
G2: General requirements - 42 CFR § 438.402	100.0%	100.0%	100.0%	100.0%
G3: Timely and adequate notice of adverse benefit determination - 42 CFR § 438.404	70.0%	70.0%	100.0%	70.0%
G4: Handling of grievances and appeals - 42 CFR § 438.406	83.3%	100.0%	100.0%	100.0%
G5: Resolution and notification - 42 CFR § 438.408	61.5%	76.9%	84.6%	92.3%
G6: Expedited resolution of appeals - 42 CFR § 438.410	66.7%	66.7%	100.0%	100.0%
G7: Information about grievance and appeal system to providers and subcontractors - 42 CFR § 438.414	0.0%	0.0%	0.0%	100.0%

Standard	CCHP	DHP	GHC-SCW	MCHP
G8: Record keeping requirements - 42 CFR § 438.416	100.0%	100.0%	100.0%	100.0%
G9: Continuation of benefits while the local appeal and the state Fair Hearing are pending - 42 CFR § 438.420	100.0%	50.0%	25.0%	100.0%
G10: Effectuation of reversed appeal resolution - 42 CFR § 438.424	100.0%	50.0%	100.0%	100.0%

BC+ and SSI MCO Compliance with Standards Comparison Results – Grievance System Standards

Standard	Anthem	GHC-EC*	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
G1: Grievance systems - 42 CFR § 438.228	80.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
G2: General requirements - 42 CFR § 438.402	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%
G3: Timely and adequate notice of adverse benefit determination - 42 CFR § 438.404	90.0%	14.3%	90.0%	100.0%	100.0%	100.0%	70.0%	100.0%	100.0%
G4: Handling of grievances and appeals - 42 CFR § 438.406	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
G5: Resolution and notification - 42 CFR § 438.408	84.6%	84.6%	100.0%	92.3%	92.3%	92.3%	76.9%	100.0%	76.9%
G6: Expedited resolution of appeals - 42 CFR § 438.410	66.7%	33.3%	66.7%	100.0%	66.7%	100.0%	100.0%	100.0%	66.7%

Standard	Anthem	GHC-EC*	*i*Care	MHS	MHWI	NHP	Quartz	SHP	UHC
G7: Information about grievance and appeal system to providers and subcontractors - 42 CFR § 438.414	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
G8: Record keeping requirements - 42 CFR § 438.416	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
G9: Continuation of benefits while the local appeal and the state Fair Hearing are pending - 42 CFR § 438.420	75.0%	50.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	75.0%
G10: Effectuation of reversed appeal resolution - 42 CFR § 438.424	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

*GHC-EC's results are from a CY 2022 Compliance with Standards Review, which preceded its NCQA Accreditation in CY 2023.

Appendix 4 – Provider Data Reviews

Provider Directory Reviews

To ensure the secret shopper calls were based on current information, the MCO's online directory for Wisconsin Medicaid was used to locate the provider and provider type/specialty, and to collect the current directory phone number, address, and provider availability for the providers selected for sampling. The table below summarizes the count of providers found in the online directories.

Description	Provider Count
Number of providers sampled and researched (denominator)	1,000
Providers not found in online MCO directory	418
Providers found in online MCO directory (numerator)	582
Percentage of providers found in directory	**58.2%**

The table below summarizes the discrepancies found when reviewing the health plan's online provider directory compared to online sources such as the provider's website or Google Maps.

Discrepancy	Provider Count
Number of providers found in MCO directory (denominator)	582
Provider address only	7
Provider phone number only	131
Both address and phone number	108
Number of providers with at least one discrepancy	**246**
Percentage of providers with at least one provider directory discrepancy	**42.3%**

In addition to contact information and provider type, the Accepting New Patients indicator was evaluated across data sources. The table below compares the percent of Sampled Providers that were Accepting New Patients, between three different sources: the health plan-submitted file, the online directory, and the online research.

MCO	Online Directory Matched Provider File (HPN)	Online Directory Matched Provider Website	Online Directory Matched Provider File and Provider Website
Anthem	93.7%	33.3%	30.2%
CCHP	91.8%	44.9%	42.9%
DHP	96.1%	19.6%	19.6%
GHC-EC	96.2%	21.2%	21.2%
GHC-SCW	15.2%	9.1%	3.0%
*i*Care	100.0%	33.3%	33.3%
MCHP	100.0%	10.4%	10.4%
MHS	95.7%	38.3%	38.3%
MHWI	77.3%	27.3%	27.3%
NHP	95.7%	38.3%	38.3%
Quartz	54.3%	17.4%	15.2%
SHP	92.9%	14.3%	14.3%
UHC	86.7%	34.7%	30.6%
Statewide	**85.0%**	**26.8%**	**25.3%**

Additional Information from the Survey

The table below details the Accepting New Patients indicators that matched the call survey, did not match, are a partial match (e.g. one indicator is 'Yes' and the other is 'By Referral Only'), or are unknown due to insufficient information provided to the caller.

MCO	Online Directory Matched Call Survey	Online Directory Matched All Sources
Anthem	71.4%	42.9%
CCHP	59.3%	44.4%
DHP	52.0%	24.0%
GHC-EC	35.7%	14.3%
GHC-SCW	18.2%	0.0%
*i*Care	0.0%	0.0%
MCHP	54.2%	8.3%
MHS	56.5%	47.8%
MHWI	50.0%	37.5%

MCO	Online Directory Matched Call Survey	Online Directory Matched All Sources
NHP	56.5%	47.8%
Quartz	78.9%	21.1%
SHP	63.3%	16.7%
UHC	65.9%	43.9%
Statewide	**58.6%**	**31.4%**

The callers also verified the location of the appointment, when possible, to ensure it matched the call list. The table below details the survey results regarding provider appointment location.

MCO	Percent of Locations Verified as a Match
Anthem	93.8%
CCHP	85.7%
DHP	87.5%
GHC-EC	N/A
GHC-SCW	100.0%
*i*Care	40.0%
MCHP	87.5%
MHS	100.0%
MHWI	50.0%
NHP	100.0%
Quartz	50.0%
SHP	100.0%
UHC	85.7%
Statewide	**88.4%**

When the original provider was not available for an appointment, the callers could indicate if an alternative provider or telehealth option was offered in an expanded view of network adequacy. The table below details the number of times an alternative provider and/or telehealth option was offered.

MCO	Alternative Provider Offered	Telehealth Offered
Anthem	3	0
CCHP	4	0
DHP	11	0
GHC-EC	1	0
GHC-SCW	7	0

MCO	Alternative Provider Offered	Telehealth Offered
*i*Care	3	0
MCHP	4	0
MHS	2	0
MHWI	4	0
NHP	2	0
Quartz	5	0
SHP	7	0
UHC	13	3
Statewide	**66**	**3**