



WISCONSIN DEPARTMENT
of **HEALTH SERVICES**

MEDICAID MANAGED CARE QUALITY STRATEGY

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STATE OF WISCONSIN

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Executive Summary

The Wisconsin Department of Health Services (DHS) Division of Medicaid Services (DMS) has broad quality goals that include improving access, member choice, and health equity; promoting appropriate, efficient, and effective care; focusing on patient or person-centered care and superior clinical and personal outcomes; and employing principles of evidence-based continuous quality improvement. These goals, as well as the objectives, strategies, programs, specific interventions, and activities intended to achieve the goals (defined in the [glossary](#)), and the process for monitoring progress toward these goals are described in the Wisconsin Medicaid Managed Care Quality Strategy document (Quality Strategy).

The Quality Strategy was prepared by DMS in accordance with requirements from Centers for Medicare & Medicaid Services (CMS) for states to develop a strategy to assess and improve the quality of managed care services offered to Medicaid beneficiaries. It articulates compliance with the federal Medicaid managed care rule, 42 C.F.R. § 438.340 (2016) requirements. While the Quality Strategy is specifically focused on Wisconsin Medicaid members receiving acute and/or long-term managed care services, the quality goals apply to all programs in which Medicaid members are enrolled, including fee-for-service members.

In Wisconsin, acute care services for managed care members are furnished by BadgerCare Plus and Supplemental Security Income (SSI) health maintenance organizations (HMOs). Long-term care services for managed care members are furnished by Family Care and Family Care Partnership long-term care managed care organizations (MCOs), which are also known as prepaid inpatient health plans. Although there is alignment and substantial overlap between acute care and long-term care goals, objectives, and strategies, some divergence is necessary to address the specific needs of the members served by each program. This document reflects these similarities and differences and is organized to demonstrate the relationship between goals, objectives, strategies, programs, activities, and interventions for both acute care and long-term care within the context of four domains:

1. Access to care and member choice
2. Cost-effectiveness
3. Person-centered care and member experience
4. Health outcomes and reducing disparities

Goals and objectives within these domains are presented below.

Access to Care and Member Choice			
Acute Care		Long-Term Care	
Goal 1	Improve access to appropriate care for primary, behavioral health, and dental care in BadgerCare Plus and SSI HMOs.	Goal 1	Empower Family Care and Family Care Partnership members with access to an array of services and supports.

Acute Care		Long-Term Care	
	<p>Objectives Ensure adequacy of behavioral health and dental care providers in BadgerCare Plus and SSI HMO networks.</p>		<p>Objectives</p> <ul style="list-style-type: none"> • Reduce the length of stay of Family Care and Family Care Partnership members in institutions for mental disease after the member is determined psychiatrically stable. • Offer a wider range of relevant data to Family Care and Family Care Partnership consumers (for example: member satisfaction survey results, pay-for-performance results, interdisciplinary teams, staffing ratios and turnover, information about sanctions). <p>Implement legislative initiatives to promote access to care.</p>
Cost-Effectiveness			
Acute Care		Long-Term Care	
<p>Goal 2</p> <p>Control health care costs in BadgerCare Plus and SSI HMOs through enhanced value-based purchasing and efficiency.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Increase the proportion of total payments made by DMS to BadgerCare Plus and SSI HMOs and, in turn, by these HMOs to providers through value-based purchasing arrangements. • Reduce unnecessary, inefficient, and uncoordinated care through alternative and innovative payment arrangements for BadgerCare Plus and SSI HMOs. 		<p>Goal 2</p> <p>Promote efficient and cost-effective services and supports in Family Care and Family Care Partnership through innovation, standards, data-driven quality, and evidence-based practices.</p> <p>Objectives</p> <p>Increase the number of pay-for-performance measures included in each long-term care MCO contract.</p>	

Person-Centered Care and Member Experience			
Acute Care		Long-Term Care	
Goal 3 Improve engagement of BadgerCare Plus and SSI HMO members in their care and experience of care. Objectives <ul style="list-style-type: none"> • Increase engagement of BadgerCare Plus and SSI HMO members in self-care, and increase provider-delivered care that is culturally competent for BadgerCare Plus and SSI HMO members. • Improve the care experience of BadgerCare Plus and SSI HMO members by monitoring, publicly reporting, and using member feedback. 		Goal 3 Focus on the whole person in Family Care and Family Care Partnership, including physical, psychosocial, and spiritual needs to live and work freely in the home and community. Objectives <ul style="list-style-type: none"> • Increase the percentage of Family Care and Family Care Partnership members who live in a private residence (i.e., home, family home, apartment). • Increase the rate of competitive integrated employment of Family Care and Family Care Partnership members who want to work. 	
		Goal 4 Engage Family Care and Family Care Partnership members to make meaningful choices about where and with whom they live, and their services and who provides them. Objectives <ul style="list-style-type: none"> • Increase the percentage of Family Care and Family Care Partnership members who self-direct at least one service in their care plan. • Increase the percentage of Family Care and Family Care Partnership subcontractors with standards that are in compliance with provider selection and retention standards set by DMS. • Increase the percentage of Family Care and Family Care Partnership members who report living in the setting they prefer. 	

Health Outcomes and Reducing Disparities			
Acute Care		Long-Term Care	
Goal 4	<p>Improve health outcomes for BadgerCare Plus and SSI HMO members at the individual and population health levels.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Increase the proportion of BadgerCare Plus and SSI HMO members receiving high-quality care management services. • Improve care and treatment for BadgerCare Plus and SSI members with mental health and substance abuse conditions. 	Goal 5	<p>Ensure continuous improvement of high-quality programs to achieve the goals and outcomes identified by Family Care and Family Care Partnership members.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Increase the percentage of service plans that address the assessed needs and personal goals of Family Care and Family Care Partnership members. • Increase the percentage of Family Care and Family Care-Partnership members for whom services, as identified in the member-centered plan, were implemented consistently with the plan.
Goal 5	<p>Reduce health disparities experienced by BadgerCare Plus and SSI HMO members based on age, race, ethnicity, gender, primary language spoken, disability status, and geographic location.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Reduce health disparities, as reflected in access, quality, and health outcomes, experienced by BadgerCare Plus and SSI HMO members. • Reduce infant mortality rates among African American BadgerCare Plus and SSI HMO members. 		

To achieve these quality goals and objectives, DMS will employ three types of strategies: payment levers; delivery system and person-centered care approaches; and member engagement and choice initiatives.

Payment: DMS is expanding value-based reimbursement arrangements to increasingly align payments to health outcomes. These arrangements include pay-for-performance on clinical measures and member satisfaction scores, alternative payment models for BadgerCare Plus and SSI HMOs, and reducing potentially preventable hospital readmissions.

Delivery system and person-centered care: Delivery system strategies focus on the way HMOs, MCOs, and providers care for patients. These strategies emphasize care management and coordination, use of health homes and medical homes for specific conditions and populations, and continual attention to the health and safety of Medicaid members. Person-centered care strategies focus on building partnerships between members and their care teams around high-quality, evidence-based, accessible care in which individual needs, preferences, and values of members and caretakers are paramount.

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

The Quality Strategy also describes the use of health information technology to support Medicaid business operations and administration, accelerate quality measurement and reporting, and facilitate member engagement. The document concludes with a section on quality assurance, which describes how DMS complies with the federal guidelines for ensuring the quality of care provided to members.

1. Introduction

Wisconsin Medicaid programs offer high-quality, person-centered managed care to members. The Wisconsin Medicaid Managed Care Quality Strategy document (Quality Strategy) outlines the Wisconsin Department of Health Services (DHS) Division of Medicaid Services (DMS) managed care quality goals, objectives, strategies, and programs intended to achieve the overarching goals of DMS, as well as to establish a process for monitoring progress toward these goals. In alignment with the Triple Aim,¹ the Quality Strategy provides a structure to improve individual and population health and the member experience of care, while managing the costs of care. This document was prepared by DMS, the division responsible for overseeing the Medicaid program.

a. Purpose

This document meets the federal requirements of 42 C.F.R. § 438.340 (2016) to describe the strategies for assessment and quality improvement of managed care services offered to Medicaid beneficiaries. It includes the specific strategies Wisconsin will use to align programs to best meet the health care needs of Medicaid members and continually improve health for Wisconsin residents.

This Quality Strategy sets a three-year vision for DMS to achieve its quality goals and objectives, and is intended to evolve over time.

b. Scope

DMS has a broad view of quality that includes improving access, member choice, and health equity; promoting appropriate, efficient, and effective care; focusing on patient-centered care and superior clinical outcomes; and employing principles of evidence-based continuous quality improvement. While the scope of this Quality Strategy is specifically focused on Wisconsin Medicaid members receiving acute care and/or long-term care managed care services, the concepts and ideas apply to all programs in which Medicaid members are enrolled, including fee-for-service members. Acute care services for managed care members are furnished by BadgerCare Plus and Supplemental Security Income (SSI) health maintenance organizations (HMOs). DMS has dedicated acute care teams that manage the BadgerCare Plus and SSI HMOs. Long-term care services for managed care members (e.g., managed long-term care services and supports) are furnished by Family Care and Family Care Partnership long-term care managed care organizations (MCOs). DMS also has dedicated long-term care teams that manage the long-term care MCOs. Although there is alignment and substantial overlap between acute care and long-term care program area goals, objectives, and strategies; some divergence is

¹ Institute for Healthcare Improvement (IHI). IHI Triple Aim Initiative. <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>. Updated 2017.

necessary to address the specific needs of the members served by each program. This document is organized to reflect these similarities and differences.

The following graphic illustrates the goals, objectives, strategies, and program relationships articulated in the document.

FIGURE 1



This document concludes with a section on quality assurance, which describes how DMS complies with the federal guidelines, § 438.340, for ensuring the quality of care provided to members.

c. History of Medicaid in Wisconsin

Acute care: In 1984, in several southeastern and southcentral counties, Wisconsin Medicaid began paying for and delivering services through acute care HMOs. In 1994, Medicaid began voluntary enrollment of populations with special health care needs in managed care programs, including individuals deemed disabled and eligible for SSI. Wisconsin expanded the use of HMOs to include most of the remainder of the state for the core Medicaid population in 1997 and SSI population in 2004. Beginning in the mid-1990s, Wisconsin developed a number of voluntary managed care demonstration programs. Children Come First started in Dane County in 1993 and Wraparound Milwaukee started in Milwaukee County 1997. These programs provide behavioral health services to children with severe emotional disturbances in home and community settings rather than in residential treatment centers and inpatient psychiatric hospitals.

In 1999, Wisconsin added BadgerCare to provide Medicaid acute, primary, and behavioral services to parents and children. Then in 2008, under a federal demonstration waiver, BadgerCare merged Medicaid with Children’s Health Insurance Program to create BadgerCare Plus. From 2009 through 2013, eligibility was extended to childless adults with income up to 200% of the federal poverty level with a capped enrollment. In 2014, eligibility was amended to include parents and caregivers and childless adults with income up to 100% of the federal poverty level, covering all adults living in poverty for the first time. Wisconsin also received federal approval in 2014 to operate a medical home, Care4Kids, to provide benefits to foster children through a non-risk prepaid inpatient health plan. Currently, most BadgerCare Plus beneficiaries and SSI adults are required to enroll in a managed care plan.

Long-term care: Wisconsin has long been recognized as a national leader in developing flexible and creative community supports for long-term care members. In 1995, Wisconsin began redesigning the long-term care system for older adults and adults with disabilities who qualify for institutional levels of care, individuals eligible for full benefit Medicare and Medicaid, by creating Family Care Partnership. Family Care Partnership provides members in 14 counties with Medicaid long-term care services and supports and Medicare acute care benefits through Medicare Advantage Special Needs Plans.

In 1998, Wisconsin began offering Family Care to long-term care members. Family Care was developed with extensive involvement of citizens with physical disabilities, developmental disabilities, or those who are elderly, and their representatives. The Family Care and Family Care Partnership programs were developed with four specific goals:

- Provide people with improved options from which to choose where they live, and what kinds of services and supports they receive to meet their needs.
- Improve access to services.
- Improve quality through a focus on health and social outcomes.
- Create a cost-effective system for the future.

In 2006, the Wisconsin Legislature’s Joint Committee on Finance approved Family Care to move out of its pilot phase, and begin expansion in 2007. By the end of 2018, Family Care will be fully expanded statewide and will continue to provide all Medicaid-covered long-term care services and supports, as well as outpatient behavioral health, to people who qualify for or are at risk of an institutional level of care. Family Care and Family Care Partnership will continue to work to keep members in their homes or in the least restrictive setting for as long as possible.

Medicaid Managed Care History Timeline

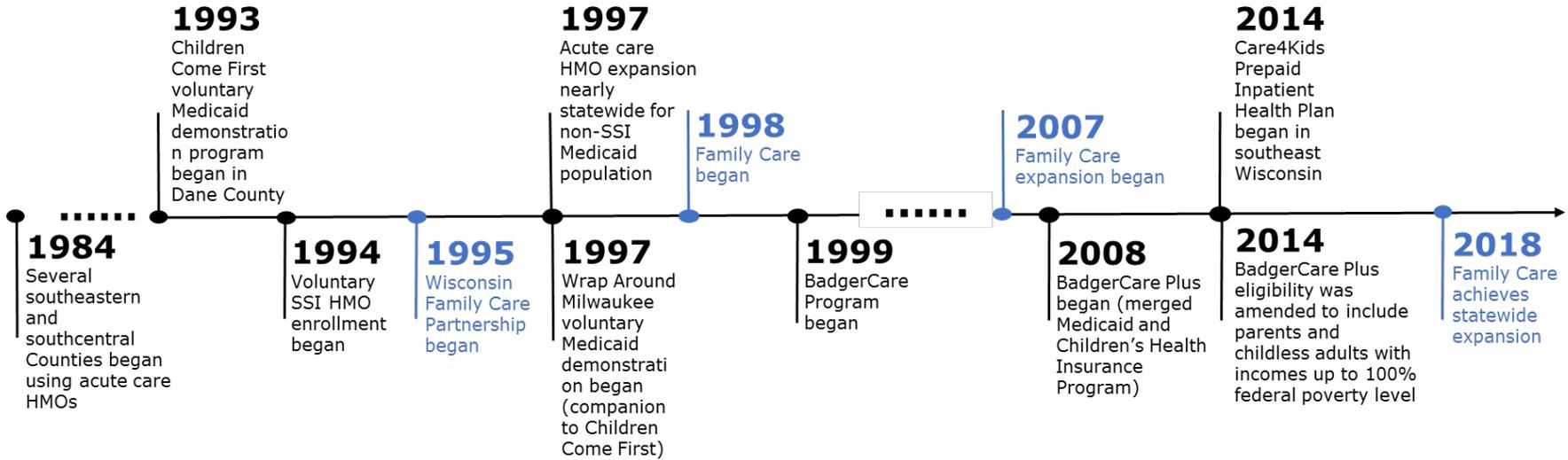


FIGURE 2

2. Methods and Process for Development: § 438.340(c) and (d)

The Quality Strategy was developed by DMS staff and leadership through a series of visioning sessions, internal assessments and meetings, and stakeholder feedback. To support the development of the Quality Strategy, DMS used the Wisconsin Medicaid quality framework, a logic model that aided in demonstrating the alignment of strategies and programs with overarching goals and specific objectives, as well as identified resource and infrastructure needs, and ongoing evaluation efforts. The quality framework can be found in the Appendices.

a. Public Comment Process: § 438.340(c) and (d)

The draft Quality Strategy document will be made available February 20 through April 21, 2018, for comment by stakeholders and the general public through a number of outreach efforts. This input included advisory committees and councils, tribal consultation, and publication on the DHS website. Following the 60-day public comment period, all feedback will be reviewed and responses will be provided to each discussion point. Appendix 8e will include a summary of comments received on the Quality Strategy, responses provided, and any associated updates to the Quality Strategy. The final version of the Quality Strategy will be available on the DHS website.

b. Process for Review and Update of the Quality Strategy: § 438.340(c)

DMS will review and update the Quality Strategy at a minimum of every three years. If there is a significant change in the interim, as defined by a change in a goal or a strategy, DMS will update the Quality Strategy to reflect this change, solicit public comment, and request CMS approval.

3. Organizational Goals, Objectives, and Foundational Principles

DHS has established its mission, visions, and values. As a division of DHS, DMS has established its own quality domains, goals, objectives, and foundational principles to support the DHS mission and guiding principles. These components are described in the following section.

a. DHS Mission, Vision, and Values

Mission: To protect and promote the health and safety of the people of Wisconsin.

Vision: Everyone living their best life.

Values:

- Focus on the needs of the people we serve.
- Foster independence.
- Address health disparities.
- Value our colleagues and recognize excellence.
- Encourage innovation and critical thinking.
- Collaborate with our partners.
- Manage public resources responsibly.

b. DMS Mission, Vision, Values

Mission: Improving lives through high-value services that promote health, well-being and independence.

Vision: People empowered to realize their full potential.

Values:

- Serve people through culturally competent practices and policies.
- Foster a supportive and trusting, team-oriented culture that recognizes excellence and provides opportunities for development.
- Build collaborative relationships with both internal and external stakeholders and partners.
- Encourage innovative, data-driven, and collaborative decision-making.
- Communicate respectfully and effectively.
- Accountable for high-value service delivery and customer service.

c. Foundational Principles

Foundational principles are values that guided the development of the DMS quality goals, strategies, and programs, and are reinforced through activities, interventions, metrics, and performance monitoring. Foundational principles demonstrate the commitment of DMS to health equity, fiscal responsibility, decision-making supported by evidence, and person-centered care. These foundational principles encompass specific elements for acute care and long-term care.

- **Whole person:** Focus on the whole person, including their physical, psychosocial, and spiritual needs to live and work freely in their home and community and to improve well-being.
- **Evaluate and address health disparities:** Consider the impact on health disparities when developing, implementing, and managing all programs and initiatives. This will include

addressing social determinants of health and supporting access to community services and supports.

- **Access:** Empower people with access to an array of services and supports. Ensuring member access to care drives decision-making in our program management.
- **Choice:** Engage people to make meaningful choices about where and with whom they live, and their services and who provides them. Consider member preferences, health and social needs, person-centered care, and member engagement when making decisions about DMS programs and initiatives.
- **Use data to evaluate programs and inform decision making:** Use data to evaluate and make timely decisions about policies, strategies, programs, and infrastructure needs.
- **High-quality:** Ensure continuous improvement of high-quality programs to achieve member's identified goals and outcomes.
- **Collaboration:** Foster collaborative relationships through robust and transparent communication.
- **Cost-Effective— Be good stewards of Medicaid funds:** Promote efficient and cost-effective services and supports through innovation, standards, data-driven quality, and evidence-based practices. Maximize the value of each dollar spent, as reflected by cost-effectiveness, accountability for the management of contracts, and quality of services provided to Medicaid members.
- **Leadership:** Lead the nation in developing innovative approaches for improving the delivery of acute and long-term care services and supports.
- **Engage:** Provide a workplace with opportunities for staff engagement and personal and professional growth.

d. DMS Quality Goals and Objectives: § 438.340(b)(2)

The DMS quality goals align with and support the DHS and DMS visions, missions, and guiding principles. Each goal includes specific objectives.

Goals and objectives for acute care and long-term care programs fall under four domains:

1. Access to care and member choice
2. Cost-effectiveness
3. Person-centered care and member experience
4. Health outcomes and reducing disparities. Each is described in the table below.

The objectives reflect evidence about key issues that affect Wisconsin Medicaid members, and support DMS goals in the four domains listed above.

Access to Care and Member Choice

Acute Care		Long-Term Care	
Goal 1	<p>Improve access to appropriate care for primary, behavioral health, and dental care in BadgerCare Plus and SSI HMOs.</p> <p>Objectives Ensure adequacy of behavioral health and dental care providers in BadgerCare Plus and SSI HMO networks.</p>	Goal 1	<p>Empower Family Care and Family Care Partnership members with access to an array of services and supports.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Reduce the length of stay of Family Care and Family Care Partnership members in institutions for mental disease after the member is determined psychiatrically stable. • Offer a wider range of relevant data to Family Care and Family Care Partnership consumers (for example: member satisfaction survey results, pay-for-performance results, interdisciplinary teams, staffing ratios and turnover, information about sanctions) . • Implement legislative initiatives to promote access to care.

Cost-Effectiveness			
Acute Care		Long-Term Care	
Goal 2	<p>Control health care costs in BadgerCare Plus and SSI HMOs through enhanced value-based purchasing and efficiency.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Increase the proportion of total payments made by DMS to BadgerCare Plus and SSI HMOs and, in turn, by these HMOs to providers through value-based purchasing arrangements. • Reduce unnecessary, inefficient, and uncoordinated care through alternative and innovative payment arrangements for BadgerCare Plus and SSI HMOs. 	Goal 2	<p>Promote efficient and cost-effective services and supports in Family Care and Family Care Partnership through innovation, standards, data-driven quality, and evidence-based practices.</p> <p>Objectives</p> <p>Increase the number of pay-for-performance measures included in each long-term care MCO contract.</p>
Person-Centered Care and Member Experience			
Acute Care		Long-Term Care	
Goal 3	<p>Improve engagement of BadgerCare Plus and SSI HMO members in their care and experience of care.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Increase engagement of BadgerCare Plus and SSI HMO members in self-care, and increase provider-delivered care that is culturally competent for BadgerCare Plus and SSI HMO members. • Improve the care experience of BadgerCare Plus and SSI HMO members by monitoring, publicly reporting, and using member feedback. 	Goal 3	<p>Focus on the whole person in Family Care and Family Care Partnership, including physical, psychosocial, and spiritual needs to live and work freely in the home and community.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Increase the percentage of Family Care and Family Care Partnership members who live in a private residence (i.e., home, family home, apartment). • Increase the rate of competitive integrated employment of Family Care and Family Care Partnership members who want to work.

Acute Care		Long-Term Care	
		Goal 4	<p>Engage Family Care and Family Care Partnership members to make meaningful choices about where and with whom they live, and their services and who provides them.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Increase the percentage of Family Care and Family Care Partnership members who self-direct at least one service in their care plan. • Increase the percentage of Family Care and Family Care Partnership subcontractors with standards that are in compliance with provider selection and retention standards set by DMS. • Increase the percentage of Family Care and Family Care Partnership members who report living in the setting they prefer.

Health Outcomes and Reducing Disparities			
Acute Care		Long-Term Care	
Goal 4	<p>Improve health outcomes for BadgerCare Plus and SSI HMO members at the individual and population health levels.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Increase the proportion of BadgerCare Plus and SSI HMO members receiving high-quality care management services. • Improve care and treatment for BadgerCare Plus and SSI members with mental health and substance abuse conditions. 	Goal 5	<p>Ensure continuous improvement of high-quality programs to achieve the goals and outcomes identified by Family Care and Family Care Partnership members.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Increase the percentage of service plans that address the assessed needs and personal goals of Family Care and Family Care Partnership members. • Increase the percentage of Family Care and Family Care-Partnership members for whom services, as identified in the member-centered plan, were implemented consistently with the plan.

Acute Care		Long-Term Care	
Goal 5	<p>Reduce health disparities experienced by BadgerCare Plus and SSI HMO members based on age, race, ethnicity, gender, primary language spoken, disability status, and geographic location.</p> <p>Objectives</p> <ul style="list-style-type: none"> • Reduce health disparities, as reflected in access, quality, and health outcomes, experienced by BadgerCare Plus and SSI HMO members. • Reduce infant mortality rates among African American BadgerCare Plus and SSI HMO members. 		

4. DMS Quality Strategies: § 438.340(b)

The DMS quality strategies are plans and policies designed to achieve quality goals and objectives, as defined in Section 3, and include payment reform, delivery system transformation and person-centered care, and member engagement and choice. These strategies align with the CMS Quality Strategy,² the National Quality Strategy,³ and other initiatives, such as the Medicare Quality Payment Program.⁴ These strategies will be enabled through health information technology and data infrastructure innovations.

a. Payment Strategies

Payment strategies help achieve the cost-effectiveness goals and associated objectives. DMS goals and objectives related to controlling health care costs include using enhanced, value-based purchasing and efficient and cost-effective services and supports.

The following strategies identify existing and planned initiatives; in addition, DMS will develop any additional funding mechanisms, methodologies, or programmatic changes necessary to comply with directives from the legislature and governor.

² CMS Quality Strategy. Accessed at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html>. December 3, 2017.

³ Working for Quality: The National Quality Strategy. Accessed at: <https://www.ahrq.gov/workingforquality/index.html>. December 3, 2017.

⁴ Quality Payment Program. Accessed at: <https://qualitypaymentprogram.cms.gov/>. December 3, 2017.

i. **Enhance Pay-for-Performance**

BadgerCare Plus and SSI HMOs have specific and increasingly advanced quality measure reporting requirements through the pay-for-performance initiative. This strategy puts financial incentives, withholds, and potential sanctions or penalties on BadgerCare Plus and SSI HMOs to help achieve quality goals. It also uses public reporting on pay-for-performance measures through report cards as a way to drive provider quality improvement and support other strategies, such as member engagement and activation.

In 2018, Family Care and Family Care Partnership will implement and complete a pay-for-performance initiative based on results of a member satisfaction survey. Linking pay-for-performance to member satisfaction is an important strategy of Family Care and Family Care Partnership because member satisfaction is a vital component of Wisconsin's long-term care programs. Over the next several years, additional pay-for-performance initiatives will be implemented to ensure that members are receiving high-quality services and programs are working towards achieving the Triple Aim.

ii. **Implement Alternative Payment Models through BadgerCare Plus and SSI HMOs**

Alternative payment models are financial incentives to clinicians to promote delivery of high-quality and cost-efficient care. Alternative payment models are reimbursement models that pay providers based on the quality of care they deliver, rather than the amount of services they provide. Alternative payment models are alternatives to traditional fee-for-service arrangements. They support the Medicaid managed care final rule requirements and can accelerate the movement of HMOs away from fee-for-service arrangements with their providers toward value-based arrangements.

The acute care program areas will require BadgerCare Plus and SSI HMOs to implement alternative payment models in a phased approach, using concepts similar to the Health Care Learning & Action Network alternative payment model framework.⁵ Over time, BadgerCare Plus and SSI HMOs will be expected to increase the proportion of their total payments to providers that are based on alternative payment models, and correspondingly reduce the proportion of their total payments that are based on fee-for-service arrangements.

iii. **Reduce Avoidable, Non-Value Added Care**

Public and private payers across the country are increasingly focusing on reducing avoidable care that is not value-added by monitoring measures such as potentially preventable readmission rates.

The acute care program areas will focus on reducing potentially preventable readmissions by working directly with hospitals that receive fee-for-service payments to serve Wisconsin Medicaid members, and by working with BadgerCare Plus and Medicaid SSI HMOs that serve

⁵ Alternative Payment Model Framework. Accessed at: <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>. November 29, 2017.

members through managed care. This strategy is expected to promote appropriate access to care (i.e., primary care or urgent care rather than emergency room, when appropriate).

Family Care members will also benefit from an increased focus on minimizing potentially preventable readmissions, as MCOs are responsible for managing member care before and after a member is hospitalized.

DMS defines payments to BadgerCare Plus and SSI HMOs related to reducing potentially preventable readmissions as alternative payment models, since HMOs are required to share incentives earned through potentially preventable readmission reductions with their providers.

b. Delivery System and Person-Centered Care Strategies

Delivery system strategies focus on the way HMOs, MCOs, and providers care for members. Person-centered care strategies focus on building partnerships between members and their care teams around high-quality, evidence-based, accessible care in which individual needs, preferences, and values of members and caretakers are paramount.⁶ These strategies support DMS goals and objectives related to improving access to appropriate care, improving health outcomes, and reducing disparities. Implementation of delivery system and person-centered care strategies will continue to help transform how acute care and/or long-term care services are:

- Accessed and utilized by members, and will engage members in self-management of their health and care needs.
- Delivered to members by HMOs, MCOs, and providers.
- Reimbursed, moving away from traditional fee-for-service and pay-for-volume arrangements.
- Enabled through use of health care data and information technology.
- Monitored to hold HMOs, MCOs, and providers accountable for improving the quality of care, responding appropriately to incidents when they occur, and improving the member experience.

i. Enhance Care Coordination and Person-Centered Care

Each BadgerCare Plus and SSI HMO is responsible for care coordination and care management services for their members. The HMO contract (linked in Appendices) describes robust care coordination activities that include HMOs identifying and addressing medical and social determinants of health through screening, information gathering and assessment, needs stratification, comprehensive care plan development, care plan review and updating, and appropriate transitions of care. DMS will also create requirements for effective care coordination and management, starting with SSI HMO members, that will help improve care,

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health outcomes, and experience of care for the members, and will ensure appropriate utilization of services.

Care management and coordination are also key components of Family Care and Family Care Partnership programs, with adherence to the principle that all Family Care and Family Care Partnership members retain the right and responsibility to be full partners in decisions concerning their health and long-term support services. Every member is expected to participate as the *essential* person within an interdisciplinary care team. Other members of the interdisciplinary care team include the social services coordinator, registered nurse, and additional individuals personally important to and selected by the member. Together, the interdisciplinary care team collaborates to identify the member's needs, develop long-term care and personal experience outcomes, and build the member-centered care plan. A dynamic document, the member-centered care plan is based on the initial comprehensive assessment and is updated through periodic assessments that minimally occur every six months or with a significant change in condition. The interdisciplinary care team is responsible for coordinating all services and supports, including coordination of all paid, natural, and medical supports.

As directed by the legislature and governor, DMS will develop any additional funding mechanisms, methodologies, or programmatic changes necessary.

ii. Improve Health Homes

To improve health outcomes, better engage members, and improve the member experience of care, DMS will continue to require BadgerCare Plus and SSI HMOs to improve, manage, and coordinate care for specific populations using health homes. Health homes are comprehensive care models focused on providing high-value, member-centric, coordinated care for members with specific chronic health conditions and risk factors.⁷ A medical home model, with a similar concept of coordinated care, currently offers prenatal and postpartum care for high-risk pregnant BadgerCare Plus and SSI HMOs members.

iii. Ensure Health and Safety

Ensuring member health and safety is a continual responsibility and strategy shared by the acute care and long-term care program areas, including contracted BadgerCare Plus HMOs, SSI HMOs, and long-term care MCOs. DMS ensures the health and safety of care delivered through BadgerCare Plus HMOs, SSI HMOs, and long-term care MCOs through contracting requirements and internal and external oversight. DMS also requires long-term care MCOs to engage in the discovery, investigation, remediation, and prevention of incidents that may compromise the health and safety of Family Care and Family Care Partnership members.

The comprehensive and consistent incident management systems for Family Care and Family Care Partnership accomplish this contractual requirement through three overarching critical functions:

⁷Medicaid.gov. Health Homes. Accessed at: <https://www.medicaid.gov/medicaid/ltss/health-homes/index.html> November 4, 2017.

1. Primary and secondary discovery: incident notification, initial triage and response, and investigation
2. Remediation: determination of root cause and action taken in accordance with findings
3. Quality improvement: address concerning incident patterns and trends on the individual and system levels and facilitate incident prevention

Incident follow-up and closure are significant ongoing quality assurance and improvement functions. The incident management system includes processes to assure follow-up, documentation, and closure of incidents.

Additionally, to further the shared health and safety assurance strategy, DMS program managers meet regularly with BadgerCare Plus HMO, SSI HMO, and long-term care MCO leadership. These meetings are used to identify and prioritize issues, including system improvement opportunities, and serve as a way to address questions and update HMO and MCO leadership on contract updates, fiscal updates, and new quality efforts in DMS.

c. Member Engagement and Choice Strategies

DMS promotes member and family engagement by ensuring they are partners in defining, designing, participating in, and assessing the care practices and systems that serve them to make sure these practices and systems are respectful of and responsive to individual member preferences, needs, and values. This collaborative engagement allows member values to guide all clinical decisions and drives genuine transformation in provider attitudes, behavior, and practice.⁸ These strategies for connecting members with their health coverage and care are essential for achieving quality goals and objectives. DMS has goals and objectives related to improving engagement of members in their care and experience of care, as well as focusing on empowering members to make meaningful choices about their care, supports, and services.

i. Promote Member Engagement

Active engagement of BadgerCare Plus and Medicaid SSI members in their own care and utilization of their health insurance benefits is essential for improving the quality of care and health outcomes. DMS will pursue a variety of means to enhance member engagement, including supporting and encouraging members to:

- Understand their benefits and available services.
- Actively choose their HMOs and establish care with their selected or assigned primary care provider.
- Stay with their chosen pharmacies and providers, which will help strengthen relationships between the members and providers.
- Proactively receive health screenings, preventive care, and immunizations, as appropriate.

⁸ Person and Family Engagement Strategy. CMS. Accessed at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Person-and-Family-Engagement-Strategy-Summary.pdf>. November 29, 2017.

- Work with their HMO to complete a health needs assessment and a care plan, if needed to address their health needs.
- Use online health portals available from HMOs and providers to access their health information.

Recognizing the cultural diversity of Medicaid members, DMS will also encourage HMOs to become more culturally competent through self-assessments and training staff and providers. This includes requiring BadgerCare Plus and SSI HMOs to conduct a culturally and linguistically appropriate services (CLAS)⁹ standards self-assessment and to provide information to DMS on how these standards are being integrated into their policies and procedures.

ii. Long-Term Care Choice Strategy

Choice begins with selecting a long-term care MCO (or a self-directed fee-for-service option) and working with the long-term care MCO to identify and select the services and supports that meet each member's individualized needs.

Empowering members to choose their long-term care MCO based on relevant, user-friendly, and transparently reported information is a DMS priority. The types of information provided to members will include member satisfaction scores for each long-term care MCO, pay-for-performance results, the number of members who report living in their setting of preference, the number of members who self-direct services, MCO-specific interdisciplinary care team staffing and turnover ratios, and information about sanctions, noncompliance, and National Core Indicators.[™]

The Family Care and Family Care Partnership member-centered approach includes support and guidance from the long-term care MCOs to help members to regularly identify and participate in community activities of their own choosing. This is enabled by active and integrated involvement of a member's natural and community supports and community-based service providers.

Family Care and Family Care Partnership members who meet the National Core Indicators[™] intellectual/developmental disability target group may be selected to have a National Core Indicators[™] survey administered. National Core Indicators[™] is a voluntary effort by public developmental disabilities agencies to measure and track their own performance in regards to the services that are being provided to this target group. The core indicators are standard measures used across states to assess the outcomes of services provided to these individuals and their families. The indicators measure key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. Family Care and Family Care Partnership agencies will continue to use the information received from this survey to

⁹ National Culturally and Linguistically Appropriate Services (CLAS) Standards. HHS. Accessed at: <https://www.thinkculturalhealth.hhs.gov/clas/standards>. December 4, 2017.

assess and improve the services and outcomes that are being provided to this target group and use it to compare Wisconsin to other states on a national level.

Finally, the long-term care choice strategy includes ensuring member choice includes pursuing competitive integrated employment, which involves a person-centered planning process and includes a variety of experiences that build toward successful employment. Through the development of guiding principles for competitive integrated employment, an employment best practice guide, and statewide benchmarks, Wisconsin will be a leader in providing services and supports that result in competitive integrated employment for individuals who wish to work.

5. Enabling Infrastructure: Data and Technology

Health information technology data and infrastructure play a critical role in enabling and supporting strategies to achieve DMS goals and objectives. Enabling infrastructure for health information includes technology that supports the business operations, administration, and care coordination of Medicaid service delivery (for example: Medicaid Management Information System, electronic health records, care management software).

Timely access to complete and accurate health data for DMS, providers, HMOs, and MCOs is essential for the execution of payment and delivery strategies. DMS acute care and long-term care program areas currently share many enabling technologies, such as the integrated eligibility determination system known as CARES and the Medicaid Management Information System. Each BadgerCare Plus HMO, SSI HMO, and long-term care HMOs also has their own enabling technologies for quality monitoring and improvement, including care management software and information systems. For a more detailed list of current enabling data and technology, please see Appendix 8d. DMS is interested in implementing a robust, enterprise-wide health information technology infrastructure that may involve digitizing data and processes, making electronic data (for example: claims, performance monitoring data) available to HMOs and providers, accessing and integrating clinical and administrative data, and analyzing this data for payment, results, and insights.

DMS will conduct an assessment of the current state of enabling technology and develop a future state health information technology and data implementation plan to enable successful execution of strategies.

a. Accelerate Quality Monitoring

To support implementation of the strategies outlined in this document and assessment of progress toward goals and objectives, the future data and technology plan will establish a robust electronic quality measurement system. A robust quality monitoring plan, enabled by health information technology, will support all programs by:

- Evaluating if current data systems effectively support programs and strategies and whether they collect relevant and adequate administrative, clinical, and other data from multiple sources.
- Using the statewide Health Information Exchange so that payers and providers can access real-time data to improve care coordination and deliver care, regardless of a member’s location.
- Monitoring and identifying health disparities by collecting and using appropriate member eligibility, enrollment, assessment, and care utilization data.
- Assessing and stratifying long-term care member needs through tools such as the Functional Screen.
- Supporting member engagement by providing an easily accessible public website for quality metrics reporting, and external quality review organization and program evaluation findings, in compliance with the managed care rule.

b. Use Technology to Engage Members

Technology is becoming an increasingly important way to engage members in their care. DMS aims to use health information technology enablers to help HMOs and MCOs proactively share information with members about their health status and delivery and quality of care; and encourage members to interact with HMOs, MCOs, and their providers about their care. This could include greater use of telehealth, remote patient monitoring, member education, and other tools to engage members in their care.

6. DMS Managed Care Programs

The following section provides an overview of the managed care programs serving Wisconsin Medicaid members: BadgerCare Plus, SSI, health homes and medical homes, Family Care, and Family Care Partnership. The overview describes the activities and interventions of each program that are designed to achieve managed care quality goals and objectives. Appendix 8c provides a list of the specific quality measures associated with each program.

a. Acute Care Programs

Acute care managed care programs, including BadgerCare Plus HMOs, SSI HMOs, health homes, and medical homes, are described below.

i. BadgerCare Plus HMOs

Program Description	In 1999, Wisconsin introduced BadgerCare to provide acute, primary, and behavioral health Medicaid services to parents and children. Then in 2008, under a federal demonstration waiver, BadgerCare merged Medicaid (Title XIX of the Social Security Act) with the Children’s Health Insurance Program (Title XXI of the Social Security Act) to become BadgerCare Plus. Through BadgerCare Plus, from 2009 through 2013, the state of Wisconsin extended eligibility to childless adults with income up to 200% of the federal poverty
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	<p>level at a capped enrollment. In 2014, eligibility was amended to include parents and caregivers and childless adults with income up to 100% of the federal poverty level.</p> <p>Eligible BadgerCare Plus members are required to enroll in managed care since there are at least two or more HMOs covering every county in the state. Currently, there are 18 HMOs serving BadgerCare Plus members.</p> <p>Any HMO that meets state network adequacy requirements and additional qualifications can contract to provide services with Wisconsin Medicaid. Rates are actuarially sound and set annually by DMS and its actuaries. HMOs are required to participate in the pay-for-performance program (with up to 2.5% upfront withhold), core reporting, and other reporting. Further quality assurance requirements are outlined in Section 6.</p>
<p>Activities and Interventions</p>	<p>Payment strategy:</p> <ul style="list-style-type: none"> • Pay-for-performance and core reporting • Alternative payment model threshold <p>Delivery system and person-centered care strategy:</p> <ul style="list-style-type: none"> • Performance improvement projects • Potentially preventable readmissions • Health needs assessment • Care Plans <p>Member engagement and choice strategy:</p> <ul style="list-style-type: none"> • Consumer Assessment of Healthcare Providers and Systems for children • Public reporting, including website and report cards • Prevalent language rules
<p>Next Steps</p>	<p>DMS will focus on implementing the payment reform strategy in BadgerCare Plus HMOs, through pay-for-performance, advancing an alternative payment methodology threshold requirement, and reducing potentially preventable readmission rates. The BadgerCare Plus HMO program will also increase member engagement initiatives as a strategy to achieve objectives related to member engagement and experience of care. DMS has also submitted an 1115 Waiver¹⁰ to CMS for childless adults, which would require additional activities and interventions for this population.</p>

¹⁰ About Section 1115 Demonstrations. CMS. Accessed at: <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>. December 4, 2017.

ii. SSI HMOs

<p>Program Description</p>	<p>In 1994, Wisconsin Medicaid created the SSI managed care program for individuals deemed disabled and eligible for supplemental security income. Originally, SSI managed care started in Milwaukee County where eligible members could enroll in HMOs voluntarily. In 2004, Wisconsin Medicaid contracted with more HMOs to expand SSI managed care into the remainder of the state.</p> <p>Starting in 2018, enrollment in HMOs is mandatory for SSI adult members who live in counties where there are two or more HMOs serving SSI members. Medicaid SSI members who have dual eligibility for Medicaid and Medicare and members who are enrolled in a Medicaid Purchase Plan (MAPP) are not subject to mandatory enrollment. Currently, there are nine SSI HMOs.</p> <p>Any SSI HMO meeting the network adequacy requirements and additional qualifications can contract with Wisconsin Medicaid to provide services to SSI members. Rates are actuarially sound and set annually by DMS and its actuaries. HMOs are required to participate in pay-for-performance (with up to 2.5% upfront withhold), core reporting, and other reporting. Further quality assurance requirements are outlined in the Quality Assurance Section.</p>
<p>Activities and Interventions</p>	<p>Payment strategy:</p> <ul style="list-style-type: none"> • Pay-for-performance and core reporting • Alternative payment models threshold <p>Delivery system and person-centered care strategy:</p> <ul style="list-style-type: none"> • Potentially preventable readmissions • Performance improvement projects • Care management initiative – needs assessment and stratification, comprehensive care plan, transitional care processes, and enhanced care coordination, including a Wisconsin interdisciplinary care team structure for members with highest needs <p>Member engagement and choice strategy:</p> <ul style="list-style-type: none"> • Public reporting, including website and report cards • Prevalent language rules
<p>Next Steps</p>	<p>DMS will implement its acute care delivery system strategy by working with SSI HMOs and the external quality review organization to ensure SSI HMOs achieve compliance with the requirements of the care management model. In 2018, DMS will require all SSI HMOs to undertake a needs stratification performance improvement project to ensure a robust stratification methodology is in place.</p>

This will allow DMS to assess effectiveness in reducing potentially preventable readmissions and to continue refining the structure of this program to achieve best results for members. DMS will identify care management best practices and encourage HMOs to adopt these best practices.

DMS will also focus on implementing the payment reform strategy in SSI HMOs, through pay-for-performance, advancing an alternative payment methodology threshold requirement, and reducing potentially preventable readmissions through the performance improvement project intervention. The SSI HMO program will also implement increased member engagement initiatives as a strategy to achieve objectives.

iii. Care4Kids Health Home

<p>Program Description</p>	<p>DHS and the Department of Children and Families partnered to implement Care4Kids, a program offering comprehensive and coordinated health services for children and youth in foster care through a prepaid inpatient health plan. Care4Kids is funded through a non-risk monthly payment with an administrative fee for care coordination (assessment and coordination) and physical and behavioral health services, which are reconciled annually to the fee-for-service costs of services provided. Care4Kids launched on January 1, 2014, in six southeastern Wisconsin counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha. Care4Kids gives parents a choice to enroll their child in a fully coordinated Medicaid medical care system or to have them receive Medicaid fee-for-service benefits. Parents may enroll or unenroll their child at any time.</p> <p>The program is designed to ensure that children in foster care receive high-quality, trauma-informed care based on a child-centric, individualized treatment plan, which includes early screening and a comprehensive health assessment at the time of entry into foster care, an enhanced schedule of well child checks, and access to dental and evidence-informed behavioral health services.</p> <p>Expected outcomes include:</p> <ul style="list-style-type: none"> • Improved physical and mental health • Improved resiliency • Shorter stays in out-of-home care. <p>These positive outcomes are also expected to result in long-term savings in publicly funded programs.</p>
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Activities and Interventions	Delivery system and person-centered care strategy: <ul style="list-style-type: none"> • Timely access to a full range of developmentally appropriate services • Screening and comprehensive initial health assessment • Comprehensive care plan • Transition health care plan • Care coordination
Next Steps	Care4Kids will focus on enhancing the development of its care model and defining and implementing additional quality measures. This will further develop the program as a center of excellence in providing coordinated care for children and youth in foster care in southeastern Wisconsin, thereby implementing the delivery system reform strategy.

iv. Children Come First / Wraparound Milwaukee

Program Description	Children Come First and Wraparound Milwaukee are two county-based prepaid inpatient health plans that offer multi-agency, community-based mental health and alcohol and other drug abuse services under one umbrella for BadgerCare Plus and SSI youth with severe emotional disturbances. Eligible youth are enrolled in the programs through referral or court order. The programs seek to keep youth with severe emotional disturbances out of institutions and reallocate resources previously used for institutionalization to community-based wraparound services for youth with severe emotional disturbances. DMS funds Children Come First and Wraparound Milwaukee through a capitation rate for care coordination and behavioral health services, and members get their physical health care through fee-for-service.
Activities and Interventions	Delivery system and person-centered care strategy: <ul style="list-style-type: none"> • Care coordination • Child and family treatment team • Assessment of strengths and needs • Individualized service and support plan of care • Crisis plan
Next Steps	Children Come First and Wraparound Milwaukee will continue to implement the delivery system reform strategy to achieve improved access to behavioral health care. The program will work to ensure compliance with the Medicaid managed care rule.

v. HIV/AIDS Health Home

Program	The HIV/AIDS Health Home targets individuals with HIV and at least one other diagnosed chronic condition or who are at risk of developing another chronic
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Description	<p>condition. The AIDS Resource Center of Wisconsin is the sole AIDS service organization in Wisconsin. It has locations in Milwaukee, Kenosha, Brown, and Dane counties.</p> <p>In the HIV/AIDS Health Home, AIDS Resource Center of Wisconsin provides comprehensive care coordination for eligible individuals across all health care settings and between health and community care settings. The AIDS Resource Center of Wisconsin has a core team of health care professionals that includes experts in the care and treatment of individuals diagnosed with HIV infection.</p> <p>From 2012-2016, members had to be enrolled in fee-for-service. Effective January 1, 2016, the HIV/AIDS Health Home care coordination benefit was expanded to include individuals participating in home and community-based services (1915[c])¹¹ waiver program, as well as members in BadgerCare Plus and SSI HMOs.</p> <p>The HIV/AIDS Health Home is funded through a per-member-per-month care management fee and annual flat fee.</p>
Activities and Interventions	<p>Delivery system and person-centered care strategy:</p> <ul style="list-style-type: none"> • Comprehensive care management • Care coordination • Comprehensive transitional care • Member and family support • Referral to community and social support services • Screening, Brief Intervention, and Referral to Treatment (SBIRT)
Next Steps	<p>The HIV/AIDS Health Home will continue to implement the delivery system reform strategy by focusing on quality improvement, which will include requiring collection of data and quality measures to set baselines and provide metrics for program performance, and coordination of record reviews by DMS and the DHS Division of Public Health.</p>

vi. **Obstetrics Medical Home**

Program Description	<p>The Obstetrics Medical Home launched in January 2011 as a pilot limited to six southeast Wisconsin counties (Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha). In 2014, the program expanded to Dane and Rock counties and became available to SSI members. The program’s objective is to improve birth outcomes and reduce birth disparities among high-risk pregnant</p>
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¹¹ Home and Community-Based Services 1915 (c). Medicaid.gov. Accessed at: <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-c/index.html>. December 4, 2017.

	<p>women enrolled in BadgerCare Plus and SSI HMOs by providing enhanced care coordination services.</p> <p>The Obstetrics Medical Home services and care coordination interventions are delivered by clinics that are paid by the BadgerCare Plus and SSI HMOs. DMS monitors clinic and HMO performance and outcomes through external quality review organization reviews and annual reports from the clinics and HMOs. There is an enhanced, \$1,000 per member payment to clinics for meeting program criteria and an additional \$1,000 per member payment tied to positive birth outcomes (birthweight is at or over 2,500 grams and gestational age is at or over 37 weeks).</p>
<p>Activities and Interventions</p>	<p>Delivery system and person-centered care strategy:</p> <ul style="list-style-type: none"> • Patient engagement and assessment to identify needs • Patient education • Care coordination • Complex care management • Care plan • Discharge planning • Coordination with prenatal care coordination (PNCC) benefit <p>Member engagement and choice: home visits</p>
<p>Next Steps</p>	<p>The Obstetrics Medical Home will implement administrative efficiencies and focus on quality improvement to continue implementing the delivery system reform strategy and achieve the objective of improving birth outcomes and reducing birth disparities.</p>

b. Long-Term Care Programs

There are two long-term care managed care programs: Family Care and Family Care Partnership.

i. Family Care

<p>Program Description</p>	<p>Family Care, a national model in long-term care, was established in 1998. Currently, DHS contracts with five MCOs to operate Family Care in 70 counties throughout Wisconsin. As of December 2017, Family Care has a total of 46,451 members. Family Care MCOs provide or coordinate cost-effective and flexible services tailored to each member’s needs.</p> <p>DMS provides each Family Care MCO with a monthly payment for each member and the MCO uses these funds to provide and coordinate services for all of its members. Each Family Care member is the essential member of his or her own interdisciplinary care team. The team works directly with the member</p>
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	<p>to identify the member’s needs, strengths, preferences, and available resources in order to develop a person-centered plan. The person-centered plan may include help from natural supports (for example: family, friends, neighbors). When a member does not have natural supports available, the Family Care MCO will purchase the necessary services for the member.</p>
<p>Activities and Interventions</p>	<p>Payment strategy: pay-for-performance</p> <p>Delivery system and person-centered care strategy:</p> <ul style="list-style-type: none"> • Performance improvement projects • Member-centered care plan • Care management reviews • Independent file review • Family Care expansion to Dane and Adams counties <p>Member engagement and choice strategy:</p> <ul style="list-style-type: none"> • Member satisfaction survey • Adult long-term care functional screen
<p>Next Steps</p>	<p>The Family Care program will continue to focus on quality improvement, including developing additional pay-for-performance initiatives; keeping members healthy, safe, and supported in the community for as long as possible; providing increased support for behavioral health; and supporting community integrated employment.</p> <p>These activities and interventions, which are and will continue to be implemented in Family Care, are also discussed in the DMS Quality Strategies Section.</p>

ii. Family Care Partnership

<p>Current Program Design</p>	<p>In 1995, Wisconsin began redesigning the long term care system for older adults and adults with disabilities who qualify for institutional levels of care, including individuals eligible for full benefit Medicare and Medicaid, by creating Family Care Partnership.</p> <p>Currently, DMS contracts with three MCOs to operate Family Care Partnership in 14 counties throughout Wisconsin. As of December 2017, Family Care Partnership has a total of 3,098 members. Family Care Partnership MCOs provide or coordinate cost-effective and flexible services tailored to each member’s needs. In addition to ensuring each member’s long-term care service needs are met, members enrolled in Family Care Partnership receive their acute and primary care, including Medicare benefits, through the MCO.</p>
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	<p>DHS provides the MCO with a monthly payment for each member, and the MCO uses these funds to provide and coordinate services for all of its members. Each Family Care Partnership member is the essential member of his or her own interdisciplinary care team. The team works directly with the member to identify the member’s needs, strengths, preferences, and available resources in order to develop a person-centered plan. The person-centered plan may include help from natural supports (for example: family, friends, neighbors). When a member does not have natural supports available, the Family Care Partnership MCO will purchase the necessary services for the member.</p>
<p>Activities and Interventions</p>	<p>Payment strategy: pay-for-performance</p> <p>Delivery system and person-centered care:</p> <ul style="list-style-type: none"> • Performance improvement projects • Member-centered care plan • Care management reviews • Independent file review <p>Member engagement and choice strategy:</p> <ul style="list-style-type: none"> • Member satisfaction survey • Adult long-term care functional screen
<p>Next Steps</p>	<p>The Family Care Partnership program will continue to focus on quality improvement, including developing additional pay-for-performance initiatives; keeping members healthy, safe, and supported in the community for as long as possible; providing more support for behavioral health; and supporting community integrated employment.</p> <p>These activities and interventions, which are and will continue to be implemented in Family Care Partnership, are also discussed in the DMS Quality Strategies Section.</p>

6. Quality Assurance

This section describes how DMS complies with federal Medicaid managed care rule requirements in § 438.340.

a. Access Standards

To ensure member care is delivered in a timely and effective manner, BadgerCare Plus and SSI HMOs and Family Care and Family Care Partnership MCOs are held to standards for access to care. Further detail can be found within Article V of the 2018-2019 BadgerCare Plus and Medicaid SSI HMO contract, and Article VIII, Section I of the 2018 Family Care and Family Care

Partnership MCO contract. These standards are reviewed and updated annually during contracting.

i. **Network Adequacy: § 438.340(b)(1)**

Acute care: To monitor network adequacy and availability of services, DMS has established distance and waiting time standards for different provider types in the contract (for example: primary care, hospital and urgent care access, behavioral health, and dental care). BadgerCare Plus and SSI HMOs submit electronic provider files to acute care program staff on a monthly basis, which are stored in the Medicaid Management Information System. DMS reviews the provider networks every year. This review includes a provider count and comparison with fee-for-service, and mapping the providers to monitor distance standards for contract compliance. These provider maps are publically available on the [DMS website at dhs.wi.gov/badgercareplus/hmo-info-badgercareplus.htm](https://dhs.wi.gov/badgercareplus/hmo-info-badgercareplus.htm). DMS is working with the external quality review organization to ensure the network adequacy requirements from the Medicaid managed care rule, §§ 438.340 and 438.68, are met for the contracting period starting January 1, 2019.

Long-term care: DMS requires long-term care MCOs to meet all network adequacy standards required by CMS. These standards require long-term care MCOs to establish and maintain a provider network that is adequate to ensure timely delivery of all services in the benefit package. DMS must also verify all Family Care Partnership MCOs are certified by CMS to meet adequacy standards for acute and primary care providers. This includes access to a women's health specialist, access to sufficient family planning services, and access to a second opinion from a qualified health care professional upon request. Provider choice and community integration are core concepts of the DMS long-term care programs. The MCO is responsible for offering these components, while also protecting the member's health and welfare, and developing long-term supports that are in the best interest of the member.

The network adequacy standards determined by DMS encompass member enrollment, utilization of services, member target groups, and health care needs. The MCOs are also required to include network providers that are culturally competent, are able to communicate with members with limited English proficiency in their preferred language, and can ensure physical access and reasonable accommodations. DMS is working with MCOs to develop innovative technological solutions, including telemedicine and e-visits. Within their policies, administration, provider contracts, and service practices, each MCO is required to incorporate the values of honoring each member's beliefs, being sensitive to cultural diversity, and fostering staff and provider attitudes and interpersonal communication styles that respect each member's cultural background.

As of January 1, 2018, all providers that contract with and serve MCO members will be enrolled with the state pursuant to the 21st Century Cures Act of 2016.¹²

b. **Service Standards: §§ 438.340(b)(1) and 438.340(b)(5)**

Per §§ 438.340(b)(1), 438.340(b)(5), and 438.340(b) (9), DMS requires HMOs and MCOs to provide evidence-based clinical practice guidelines, meet the needs of members with special health care needs, meet transitions of care requirements, and address health disparities.

i. **Evidence-Based Clinical Practice Guidelines**

Acute care: Article X, Section B6 of the BadgerCare Plus and SSI HMO contract describes the requirement for HMOs to develop or adopt best practice guidelines in accordance with § 438.236 (b) and to disseminate those guidelines to all provides and members upon request.

Long-term care: Article VII, Section 2b and Addendum VIII of the Family Care and Family Care Partnership MCO contract describe and define practice guidelines and the benefit packages services.

ii. **Members With Special Needs**

Acute Care: Pursuant to § 438.208(c)(1), the DMS definition of members with special needs in acute care programs is based on the terminology used in clinical diagnostic and functional development. Special needs members include individuals who require additional assistance for conditions that may be medical, mental, developmental, physical, or psychological. Special needs members also includes, but is not limited to, SSI members, members who need intensive medical or behavioral case management, members enrolled in the Obstetrical Medical Home, or Birth to 3 Program members. Article III of the Badger Care Plus and SSI HMO contract discusses care management standards and outlines a specific care management model for the SSI population to support members with special needs. Article IV of the Badger Care Plus and SSI HMO contract discusses the Obstetric Medical Home and AIDS/HIV Health Homes initiatives and standards for specific support of these populations.

Long-term care: All members in Family Care and Family Care Partnership meet the definition of an individual with special health care needs pursuant to § 438.340.208(b). The program design and scope of services in these programs are individualized and intended to meet these special needs.

iii. **Transitions of Care Policy**

Acute care: Article XIV, Section C. 10 of the BadgerCare Plus and SSI HMO contract requires HMOs to notify DMS of contract terminations at least 90 days prior to the termination effective date. If an HMO decides to terminate its contract with DMS, the HMO has to comply with a transition plan that includes developing a communication plan for HMO members and

¹² 21st Century Cures Act of 2016. Congress.gov. Accessed at: <https://www.congress.gov/bill/114th-congress/house-bill/34/>. December 4, 2017

providers, submitting additional data-sharing reports for transitioning members, and providing timelines for financial reconciliation. Soon after the member enrolls in the HMO, DMS shares available Medicaid claims, encounter, and prior authorization data with a member's HMO to assist with the HMO's care coordination. In 2018, DMS will update its transitions of care policy to document how it will ensure coverage of Medicaid services and continuity of care for members who move from HMO to HMO, from fee-for-service to an HMO, or from an HMO to fee-for-service. This policy will be published online and DMS will also update the transition of care language in the 2019 BadgerCare Plus and SSI HMO contract to require each HMO to develop their own policies and procedures to meet the requirements defined in the Medicaid managed care rule § 438.62.

Long-term care: Each Family Care and Family Care Partnership MCO is contractually bound to maintain a transitions of care policy for their agency. The full details of each MCO's transitions of care policy can be found within their internal policies and procedures. Each policy is reviewed and approved by a DMS long-term care oversight team, which consists of a contract coordinator and member care quality specialist. When a Family Care or Family Care Partnership member requires a transition of care, MCOs assign care teams to review and assess the member's transitions, such as from hospital to home or nursing home to home. When a transition of care occurs, it must be specifically documented in the member assessment and member-centered plan. As needed, the DMS long-term care oversight team may coordinate discharges from facilities and is responsible for ongoing monitoring of the transition, as needed.

iv. Health Disparities

DMS plans to implement a rigorous process to identify health disparities, execute data-driven interventions to address these health disparities, and evaluate the impact and effectiveness of such interventions. As part of the current enrollment process, DMS has the ability to collect member demographic data, including age, gender, race, ethnicity, primary language, and disability status, which is stored in the Medicaid Management Information System. Members are not required to provide race, ethnicity, and primary language information for enrollment at this time. Medical services data can be collected from various data sources.

Changes to the enrollment process and to the Medicaid Management Information System are underway. The changes will enhance the collection and use of demographic data for identifying and reducing health disparities. At least annually, collected demographic data will be analyzed by the DMS quality team to identify and monitor health disparities. Current interventions to address health disparities and assess members for social determinants of health include community referrals in care plan development, the Obstetric Medical Home, the HIV/AIDS Medical Home, and a DMS-wide cultural competency committee. The DMS quality team will engage in a plan, do, study, act process to evaluate current interventions, set future reduction goals, plan and implement future interventions to reduce health disparities, evaluate current interventions, set future reduction goals, and further refine and facilitate ongoing interventions to continue to address health disparities.

As part of the health disparity reduction efforts, and pursuant to § 438.340, DMS shares member demographic information with BadgerCare Plus and SSI HMOs. Long-term care MCOs receive functional screen information, which includes race, ethnicity, and disability status. Long-term care program staff publish the long-term care scorecard and enrollment numbers, which delineate between target groups. A member's age, gender, primary language data, and disability status is transmitted to BadgerCare Plus and SSI HMOs each month. DMS is working to include race and ethnicity demographic data as part of data shared with BadgerCare Plus and SSI HMOs to fully meet the requirements in § 438.340. DMS collaborates with the DHS Division of Public Health on data collection and initiatives related to reducing health disparities in the state.

c. **Quality Assessment and Performance Improvement: § 438.340(b)(3)(ii)**

The following outlines performance improvement projects that are intended to improve access, quality, or timeliness of care for managed care members.

Acute care: The acute care Quality Assessment Performance Improvement program guidelines are within Article X of the BadgerCare Plus and SSI HMO contract. At a minimum, this program complies with § 438.330(b). Through the Quality Assessment Performance Improvement program, HMOs are required to:

- Conduct performance improvement projects designed to achieve, through ongoing measurement and interventions, significant and sustainable improvement in clinical care areas.
- Collect and submit performance measurement data.
- Have in effect mechanisms to detect both underutilization and overutilization of services.
- Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

Long-term care: The Family Care quality management guidelines and requirements are outlined in Article XII of the Family Care and Family Care Partnership MCO contract. Based on the requirements, MCOs must do the following:

- Maintain documentation of the following activities of the quality management program and have that documentation available for DMS review upon request:
 - The annual quality management work plan and its approval by the governing board or designee.
 - Monitoring the quality of assessments and member-centered care plans.
 - Monitoring the completeness and accuracy of completed functional screens.
 - Monitoring the results of care management practice related to the support provided to vulnerable/high-risk members.
 - Member satisfaction surveys.
 - Provider surveys.
 - Incident management systems.

- Appeals and grievances that were resolved as requested by the members.
- Monitoring of access to providers and verifying that the services were actually provided
- Performance improvement projects.
- Results of the annual evaluation of the quality management program.
- Monitoring the quality of sub-contractor services as noted in Article I.XVI.G.5., Contractual Relationship.
- Restrictive measures
- Performance improvement projects
- Create and approve an annual quality management work plan and evaluation.
- Maintain a health information system that collects, analyzes, integrates, and reports data that can support the objectives of the MCO's quality management program.

Family Care and Family Care Partnership MCOs have developed intensive quality case management requirements for MCOs working with members who meet the vulnerable or high-risk member definition. A vulnerable or high-risk member is someone who is dependent on a single caregiver, or two or more related caregivers to provide or arrange for the provision of nutrition, fluids, or medical treatment that is necessary to sustain life; and to whom at least one of the following applies:

- Is nonverbal and unable to communicate feelings or preferences.
- Is unable to make decisions independently.
- Is clinically complex, requiring a variety of skilled services or high utilization of medical equipment.
- Is medically frail.

Care teams working with vulnerable or high-risk members are required to provide increased supports and contacts with members and their caregivers. The Family Care and Family Care Partnership MCO quality oversight teams are required to monitor all vulnerable or high-risk members and complete an evaluation of care management practices for these members.

DMS long-term care oversight teams are integral to quality assurance of MCO activities, practices, and member care. Oversight team activities include completing intensive record reviews, providing feedback to the MCOs regarding specific members, identifying member care trends and issues that are concerning, and corresponding about corrective action plans. The long-term care quality oversight teams streamline quality monitoring of the MCO and ensure a systematic approach to quality and member care across Wisconsin.

i. Performance Improvement Projects

Acute care: Article X of the BadgerCare Plus and SSI HMO contract requires HMOs to have performance improvement projects to address the specific needs of the population enrolled in the HMO. All BadgerCare Plus and SSI HMOs are required to submit two performance improvement projects each year. HMOs that only serve the BadgerCare Plus population are required to submit PIP proposals on two different topics. HMOs that serve only the SSI

population are required to submit one performance improvement project proposal for 2018 on SSI care management and one performance improvement project on another topic. HMOs that serve both BadgerCare Plus and SSI are required to submit one performance improvement project for each population. The specific requirements of the performance improvement projects are described within the HMO quality guide and within Article X of the Badger Care Plus and SSI HMO contract.

Long-term care: All Family Care and Family Care Partnership MCOs are contractually required to identify and conduct one performance improvement project per year. The performance improvement project may be clinical or nonclinical as determined applicable to the member quality improvement needs that are assessed by each MCO. DMS maintains discretion to require up to two performance improvement projects per year.

When systems improvements are implemented through performance improvement projects, the specifications for monitoring and assessing the implemented change must be developed and adopted in compliance with the standards specified in the CMS protocol for performance improvement projects. When a performance improvement project is undertaken by each MCO, the MCO develops the process and measures for monitoring and assessing system design changes, which are approved by DMS and validated annually by the external quality review organization. If the performance improvement project is a statewide project, the process and measures for monitoring and assessing system design changes are selected by DMS and will also include consultation with the external quality review organization and the MCOs.

d. **External quality review organization: §§ 438.340(b)(4) and 438.340(b)(10)**
DMS contracts with an external quality review organization to conduct ongoing evaluations of the quality of services arranged for or provided to BadgerCare Plus and SSI HMO members in accordance with Article X, Section B7 of the BadgerCare Plus and SSI HMO contract and Article XII, Section D of the Family Care and Family Care Partnership MCO contract. The goal of external quality review organization activities is to review and validate whether each HMO and MCO is in compliance with federal and state requirements. These activities are performed consistently to ensure compliance with Medicaid provisions under Subpart E of § 438.340 and CMS protocols for use in external review of Medicaid MCOs and pre-paid health plans. The external quality review organization findings provide a basis for DMS actions toward HMO or MCO compliance remediation or quality improvement.

Primary external quality review organization activities include quality compliance reviews that are focused on enrollee rights and protections, quality assessment, and grievance systems; care management reviews; performance improvement projects and performance measures validations; and information systems capability assessment.

Specific acute care and long-term care programs have additional external reviews and evaluations performed by independent evaluators.

Acute care: DMS works with the external quality review organization on quality monitoring activities, including performance measurement validation of pay-for-performance and core reporting measures, performance improvement project review, and comprehensive reviews of

federal managed care and contract requirements. Beyond the mandatory activities, the external quality review organization validates SSI HMO care management performance, compliance with the health needs assessment requirements for childless adults, and compliance with the Obstetrics Medical Home program requirements.

For acute care, DMS is requesting CMS approval for acute care managers and the external quality review organization to use data from National Committee of Quality Assurance-accredited HMOs in the external quality review process pursuant to § 438.360 related to non-duplication of EQR activities. This request is detailed in the accreditation deeming plan in Appendix 8f.

Long-term care: DMS works with the external quality review organization to develop the standards against which it evaluates MCO performance. DMS also coordinates with the external quality review organization to ensure that the review process addresses changes within the MCOs, including expansion to new areas, mergers. DMS long-term care oversight teams review all annual external quality review organization reports. The teams identify and analyze issues that affect the overall long-term care system and recommend potential quality improvement strategies. Strategies are presented to long-term care managers and are prioritized based on the impact of the issue on:

- 1) Health and safety
- 2) Compliance with waiver assurances and other Medicaid requirements
- 3) Other priorities for Family Care quality

After each annual quality review is conducted by the external quality review organization, the respective oversight team collaborates with each MCO to develop a remediation plan, and to monitor corrective action on all unmet items as identified in the annual quality review.

i. **Accreditation Deeming Plan: § 438.360**

To recognize the efforts made by contracted BadgerCare Plus and SSI HMOs in attaining and maintaining health plan accreditation by the National Committee of Quality Assurance, DMS will streamline the administrative processes for National Committee of Quality Assurance-accredited health plans as and ensure better contract and regulatory compliance for all HMOs.

As the Quality Strategy is updated every three years, DMS will work with the external quality review organization to validate which acute care-contracted HMOs are accredited by the National Committee of Quality Assurance. Then, DMS will develop an accreditation crosswalk to document standards reviewed by the National Committee of Quality Assurance during the accreditation process, compared to standards required by DMS or the federal Medicaid managed care rule. As gaps are identified, DMS and the external quality review organization will ensure compliance is assessed through the acute care program team's HMO oversight processes (which includes HMO certification applications, contract requirements, and onsite reviews by DHS or the external quality review organization). For any areas where the HMO has met the standard during the accreditation process, they would not be subject to re-review by DMS and the external quality review organization, leading to less administrative burden for accredited plans.

Any new BadgerCare Plus and SSI HMO or plan that is not National Committee of Quality Assurance-accredited would be subject to the full compliance review of all standards by DMS and the external quality review organization.

The detailed accreditation crosswalk, list of National Committee of Quality Assurance-accredited BadgerCare Plus and SSI HMOs, and additional information about the accreditation deeming process will be detailed publicly on the ForwardHealth Portal. A link to those materials will be included in appendix 8f of the final Quality Strategy.

e. Remediation Plans

Remediation plans are the formal methods for addressing underlying issues in programs, or noncompliance with contracted services. Each program must outline and establish authority for remediation, as appropriate.

Acute care: For HMO oversight, DMS has the authority, through the Social Security Act Section 1903(m) and Article XIV of the HMO contract to levy sanctions. Sanctions include developing corrective action plans when HMOs fail to meet performance standards defined in the contract, which may result in financial penalties, enrollment restrictions, temporary management of HMOs, and termination.

Long-term care: For Family Care and Family Care Partnership MCOs, DMS has the authority to impose sanctions or terminate the contract with an MCO if the MCO fails to meet performance standards, and has violated or breached the contract between DMS and the MCO. There are multiple types of sanctions that DMS can impose on the MCO. Specifics regarding sanctions can be found in Article XVI Section E of the MCO contract, which is available in the Appendix.

i. Intermediate Sanctions

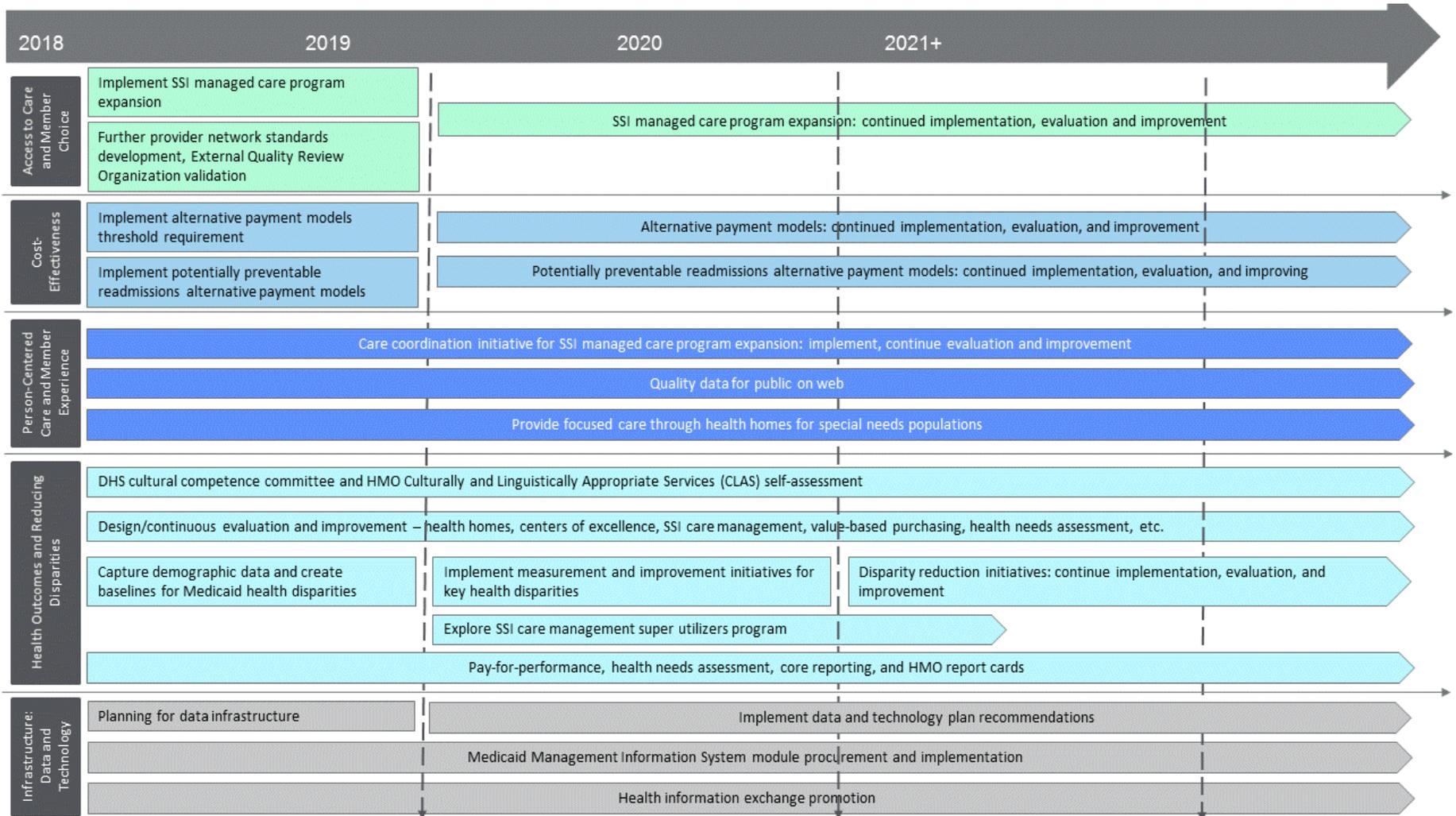
Acute care: For BadgerCare Plus and SSI HMOs, Article X, Section C, of the HMO contract identifies remedies for violation, breach, or nonperformance of contract and describes the sanctions and intermediate sanctions that are allowable in accordance with § 438.340 (b)(7) for failure to comply with the HMO contract.

Long-term care: For Family Care and Family Care Partnership, Section XVI, Article E, of the MCO contract outlines intermediate sanctions for failure to comply with the MCO contract.

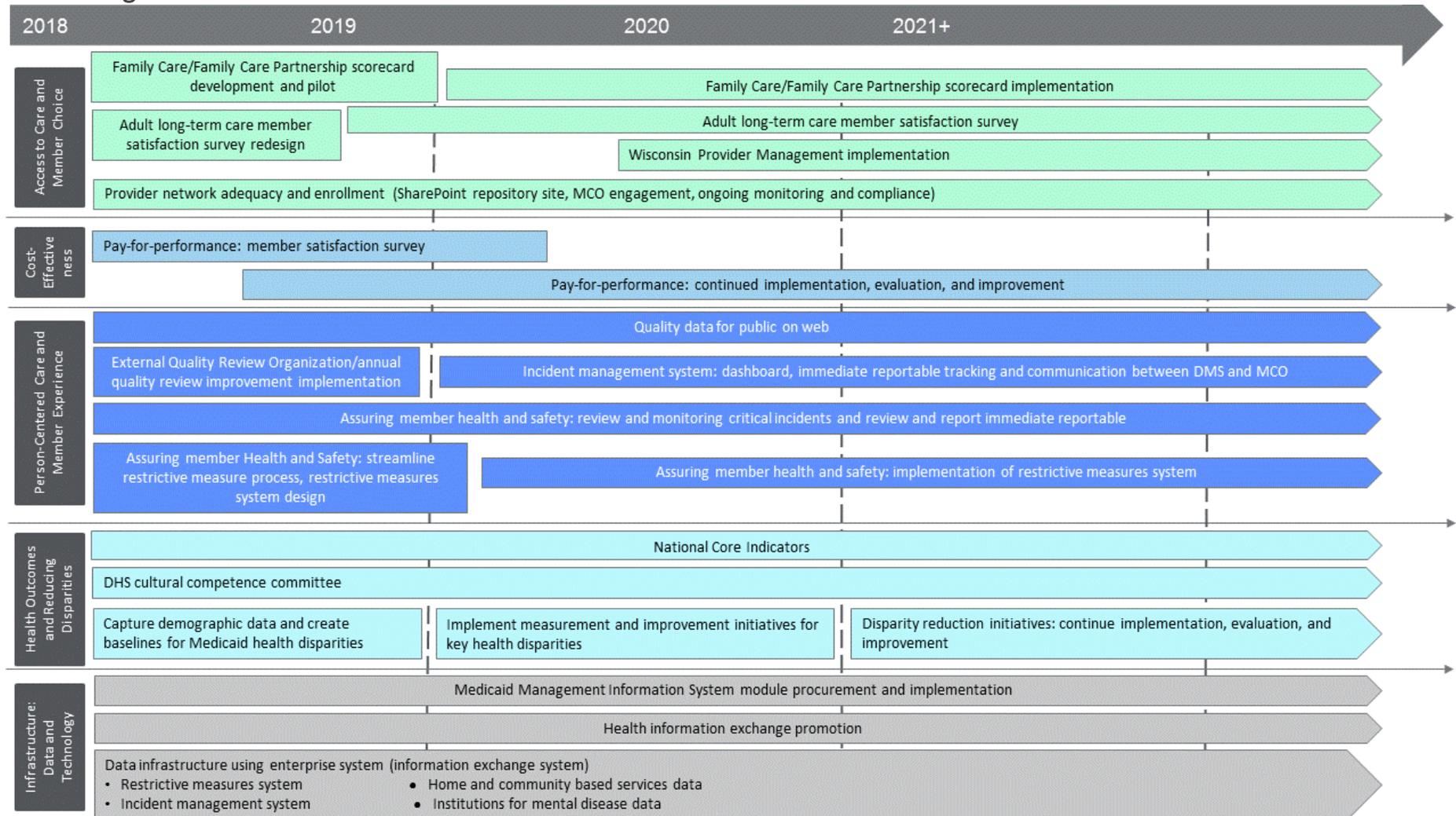
7. Roadmaps

In addition to the activities and interventions described in the previous section, DMS has created roadmaps that provide the high-level timeline of priority activities the acute and long-term care programs will be taking to implement the quality assurance strategies and help achieve the goals and objectives.

a. Acute Care



b. Long-Term Care



8. Appendices

a. Quality Framework

The quality framework was created to provide a structure for developing the Quality Strategy. The quality framework offers DMS a tool for identifying and aligning the different elements considered for the Quality Strategy and can be used as a logic model for future evaluation of programs, activities, and interventions.

The quality framework includes 13 domains listed and described below:

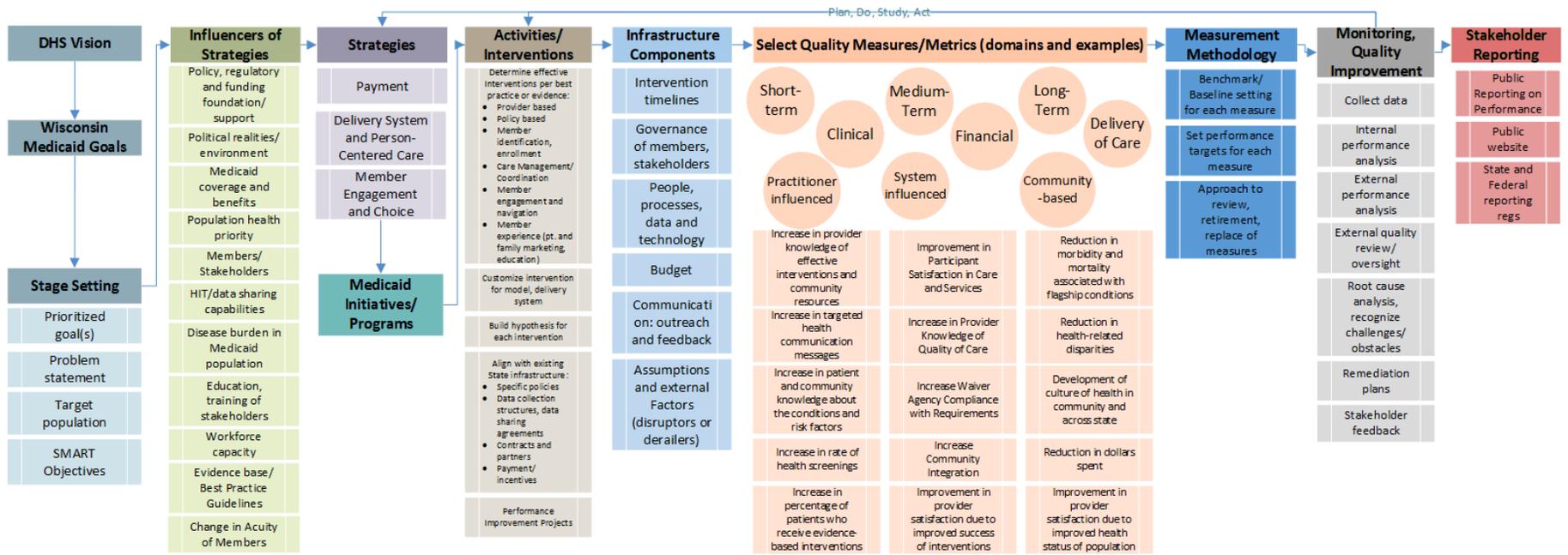
1. **Vision:** Futuristic view regarding the ideal state or conditions the organization aspires to change or create.
2. **Goals:** Long-range, broad, measurable statements that guide the organization's programs, administrative, financial, and governance functions.
3. **Stage setting:** Prioritizing goals, identifying problem statements, targeting the population, and drafting specific, measurable, achievable, relevant, and timely objectives.
4. **Influencers of strategies:** Factors influencing the strategies that are available for use.
5. **Strategies:** The methods or approaches intended to achieve objectives.
6. **Initiatives and programs:** The programmatic structure used to achieve strategies.
7. **Activities and interventions:** Specific, measurable, time bound, and actionable events that are assigned to individuals or organizations to achieve.
8. **Infrastructure components:** Fundamental enablers of program activities.
9. **Quality measure and metrics selection:** Selection of measures aligned to interventions that cover varying areas (for example: clinical, financial, care delivery) and address short, medium, and long-term outcomes.
10. **Measurement methodology:** Establishment of benchmarks, targets, and the process that will be used to review, retire, and replace measures.
11. **Monitoring and quality improvement:** Mechanisms and processes in place to monitor program performance and establish ongoing quality improvement plans and activities.
12. **Stakeholder reporting:** Mechanisms used to report on program performance to external entities.
13. **Foundational principles:** Overarching elements that will be incorporated into all quality programs and reinforced throughout the quality framework with supporting activities and interventions, metrics, and monitoring.

The quality framework is linear in structure, and starts on the left with the establishment of goals and objectives. It then moves into the stage setting process and continues to the right, assessing each of the domains. Each domain has subtopics, which are intended to assist those using the quality framework think through the implications of each area and address as many as possible, in order to inform decisions and provide a fully developed roadmap and planning effort. The foundational principles across the bottom of the quality framework are intended to

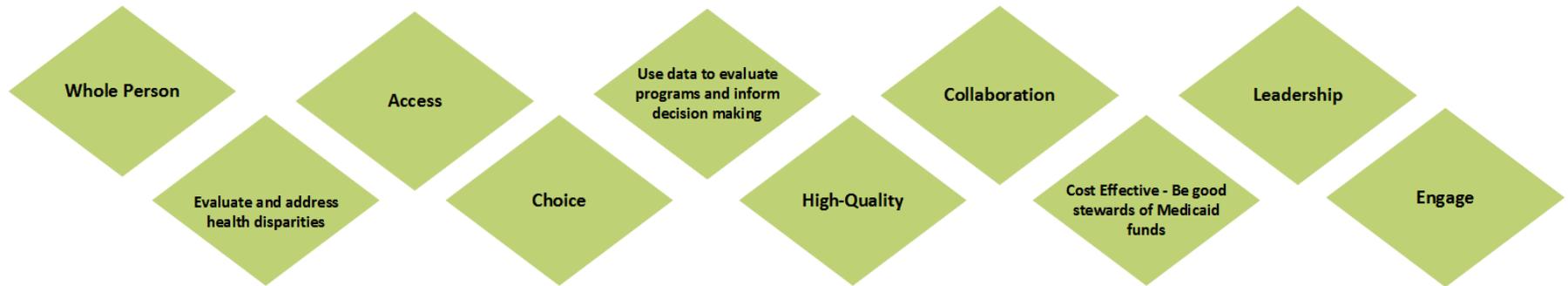
be incorporated into all programs, and applied throughout the process. For detailed definitions for each subtopic, see the Glossary.

The quality framework provides value to an organization by establishing a shared process and structure for programs, from initial program development to ongoing analysis, review, and refinement. The quality framework allows for individual program variation, but connects back to the larger enterprise quality goals and objectives. Application of the quality framework across programs can help identify gaps and begin to address challenges.

Wisconsin Medicaid Quality Framework



Foundational Principles



b. Glossary of Terms

ACCESS: ACCESS to Eligibility Support Services (ACCESS) is a self-service, internet-based application designed to assist eligible Wisconsin residents with enrolling in public assistance health and nutrition programs.

Activities and interventions: Activities and interventions refer to specific care delivery approaches, payment models, or member engagement methods designed to meet the objectives and goals of each DMS program.

Acute care: Wisconsin Medicaid acute care programs provide coverage of physical and behavioral health care.

Alternative payment model: An alternative payment model is a payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care. Alternative payment models can apply to a specific clinical condition, a care episode, or a population.

BadgerCare Plus: BadgerCare Plus is a health care coverage program for low-income Wisconsin residents who are eligible for Medicaid, and for children and pregnant women who are covered by the Children's Health Insurance Program. The Children's Health Insurance Program provides health coverage to children and families with incomes too high to qualify for Medicaid, but can't afford private coverage.

Best practice guidance: The best clinical or administrative practice or approach at the moment, given the situation and the evidence about what works for a particular situation, and the resources available. Best practice guidance is also known as promising practices and is defined as clinical or administrative practices for which there is considerable practice-based experience or expert consensus that indicates promise in improving outcomes, but for which are not yet proven by strong scientific evidence.

Capitation: Capitation refers to a specified amount of money paid to a health plan or doctor. This is used to cover the cost of a member's health care services for a certain length of time.

Care coordination: Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required member care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Care management: Care management refers to a group of integrated activities, tailored for an individual member, designed to effectively manage medical, social, and mental or behavioral health conditions. Care management programs are typically led by primary care professionals and focus on patients with chronic, high-cost conditions, such as heart disease, diabetes and

cancer, as well as those with complicated pregnancies, trauma, or other acute medical conditions, and may also address social determinants of health.

Center of excellence: A center of excellence is a facility or program that is recognized as providing the highest levels of leadership, quality, and service. Centers of excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction.

Centers for Medicare & Medicaid Services (CMS): A federal agency that is part of the Department of Health and Human Services. CMS administers Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.

Comprehensive care plan: A comprehensive care plan is a written statement of a member's needs identified during a comprehensive assessment. The plan is prepared by an interdisciplinary team and describes what support the member should get, why, when, and details of who is meant to provide it. A care plan includes the following components: assessment, diagnosis, expected outcomes, interventions, rationale, and evaluation.

Consumer Assessment of Healthcare Providers and Systems: Consumer Assessment of Healthcare Providers and Systems is a series of patient surveys rating health care experiences. Consumer Assessment of Healthcare Providers and Systems surveys cover topics important to consumers and focus on those aspects of quality that consumers are best qualified to assess.

Culturally and linguistically appropriate services standards: The national culturally and linguistically appropriate services standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

Department of Health Services (DHS): The Department of Health Services provides high-quality, affordable health care coverage and public health services to Wisconsin residents; ensures that the care provided to Wisconsin residents is high-quality and provided in accordance with state and federal law; ensures that Wisconsin taxpayer dollars are being utilized effectively and efficiently by preventing and detecting waste, fraud, and abuse; and works to continue Wisconsin's long tradition of strong health outcomes and innovation.

Division of Medicaid Service (DMS): DMS is a division within DHS that supports Wisconsin's Medicaid programs. DMS provides access to health care, long-term care, and nutritional assistance to more than one million Wisconsin residents who are elderly, disabled, or have low income. DMS administers Medicaid programs to medically needy and low-income individuals and families, as well as long-term care, support, and services for older adults, and services for people of all ages with disabilities. DMS administers other programs such as FoodShare, state-funded SSI program benefits, as well as Medicaid-funded subprograms, including primary and acute care services, Medicaid reimbursement to nursing homes, BadgerCare Plus, SeniorCare,

Family Care, Family Care Partnership, IRIS (Include, Respect, I Self-Direct), and children's long-term care services. DMS also includes the Disability Determination Bureau, which administers the federal Social Security Administration and Medicaid disability determination; and Milwaukee Enrollment Services, which administers income maintenance services for Milwaukee County.

External quality review organization: Federal law and regulations require states to use an external quality review organization to review the care provided by capitated managed care entities. External quality review organizations may be peer review organizations, another entity that meets peer review organizations requirements, or a private accreditation body.

Family Care: Family Care is a long-term care program that helps frail elders and adults with disabilities get the services they need to remain in their homes as long as possible. This comprehensive and flexible program offers services to foster independence and quality of life for members, while recognizing the need for interdependence and support.

Family Care Partnership: Family Care Partnership is an integrated health and long-term care program for frail elderly and people with disabilities

Fee-for-service: Fee-for-service is a payment method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Foundational principles: Foundational or guiding principles are overarching elements that are incorporated into all quality programs, and are reinforced throughout the quality framework application with supporting activities and interventions, metrics, and monitoring.

Goals: Goals are long-range, broad, measurable statements that guide the organization's programs and administrative, financial, and governance functions.

Health disparities: Health disparities encompass both health care disparities and health status disparities, and are health differences that are closely linked with social, economic, or environmental disadvantage. Health care disparities refer to differences in access to, availability, or quality of facilities and services. Health status disparities refer to the variation in rates of disease occurrence and disabilities between socioeconomic or geographically defined population groups.

Health home: Section 2703 of the Patient Protection and Affordable Care Act created an optional Medicaid state plan benefit for states to establish health homes to coordinate care for Medicaid members who have chronic conditions. Health home providers use a whole person approach and provide:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care and follow-up

- Patient and family support
- Referral to community and social support services

Health homes may be targeted geographically and are specifically designed for members who:

- Have two or more chronic conditions (for example: mental health disorders, substance abuse, asthma, diabetes, heart disease, obesity, or HIV/AIDS).
- Have one chronic condition and are at risk for a second chronic condition.
- Have one serious and persistent mental health condition.

Chronic conditions listed in the Affordable Care Act include mental health, substance abuse, asthma, diabetes, heart disease, and HIV/AIDS.

Health information exchange: Health information exchanges allow health care professionals and patients to appropriately access and securely share a patient’s vital medical information electronically. A health information exchange is the electronic mobilization of health care information across organizations within a region, community, or hospital system. In practice, the term health information exchange may also refer to the organization that facilitates the exchange.

Health information technology: Health information technology is a broad concept that encompasses an array of electronic technologies to store, share, and analyze health information.

Health maintenance organization (HMO): An HMO is a type of managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to members for a set amount of money every month. Members usually must get care from the providers in the plan network. HMOs provide managed care to BadgerCare Plus and SSI members.

Health needs assessment: A health needs assessment, or health risk assessment, is completed by care management staff or a primary care physician to gather in-depth clinical information about a member that can be used to identify and prioritize longer-term care management needs.

Health plans: A health plan is an entity that assumes the risk of paying for medical treatments (for example: uninsured patient, self-insured employer, payer, HMO).

Health screen: Health screens provide a high-level assessment of new beneficiaries to identify immediate care management needs. Initial health screens are typically short in length and are conducted by nonclinical staff at the time of enrollment.

Interdisciplinary care team: A team that consists of, at a minimum, a social worker or a care manager and a registered nurse. With the consumer and his or her representative (if any), other professionals (as appropriate) also participate as members of the interdisciplinary team. The interdisciplinary team conducts a comprehensive assessment of the member’s needs,

abilities, preferences, and values. The assessment looks at areas such as activities of daily living, physical health, nutrition, autonomy and self-determination, communication, and mental health and cognition.

Institution for mental disease: A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

Long-term care (LTC): Long-term care refers to variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.

Long-term service and supports: Services and supports provided to members of all ages who have functional limitations or chronic illnesses. The primary purpose is to support the ability of the beneficiary to live or work in the setting of their choice. This setting may include the member's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Managed care: Managed care systems integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and follow procedures associated with the plan; and have formal programs for quality, medical management, and the coordination of care.

Managed care organization (MCO): Each MCO receives a per person/per month payment to manage care for their members, who may be living in their own homes, group living situations, or nursing facilities. Long-term care MCO refers to the activities performed by long-term care managed care plans. MCOs are responsible for assuring and continually improving the quality of care and services consumers receive.

Measurement methodology: Measurement methodology refers to establishment of benchmarks, targets, and the process that will be used to review, retire, and replace measures.

Medicaid: Wisconsin's Medicaid program is a joint federal and state program that provides health care coverage, long-term care, and other services to over one million Wisconsin residents. There are many types of Medicaid programs. Each one has different rules about age, income, and nonfinancial requirements.

Medical home: A medical home is a care model that involves the coordinating a member's overall health care needs, similar to a health home, but it is not focused on a particular chronic condition.

Medicare: Medicare is the federal health insurance program, authorized by Title XVIII of the Social Security Act that covers people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease.

Medicaid Management Information System: The Medicaid Management Information System is a CMS-approved information technology system that supports the operation of the Medicaid program.

Member engagement: Member engagement refers to the desire, capability, and choice to actively participate in care in a way that is uniquely appropriate to the individual and in cooperation with a health care provider or organization, for the purposes of maximizing outcomes or experiences of care.

Monitoring and quality improvement: Monitoring and quality improvement refers to mechanisms and processes in place to monitor program performance and establish ongoing quality improvement plans and activities.

Network adequacy: Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to a sufficient number of primary care and specialty physicians, as well as all health care services included under the terms of the contract. Specifically, for Wisconsin Medicaid, an HMO must ensure that its delivery network is sufficient to provide adequate access to all services covered under the contract. In establishing its network, the HMO must consider:

- The anticipated enrollment of BadgerCare Plus or SSI members.
- The expected utilization of services, considering member characteristics and health care needs.
- The number and types of providers (in terms of training, experience, and specialization) required to furnish the contracted services.
- The number of network providers not accepting new patients.
- The geographic location of providers and members, distance, travel time, normal means of transportation used by members, and whether provider locations are accessible to members with disabilities.

Patient activation: Patient activation refers to the knowledge, skills, and confidence a person has in managing his or her own health and health care.

Pay-for-performance: Pay-for-performance is a term that describes health care payment systems that offer financial rewards to providers who achieve, improve, or exceed their performance on specified quality and cost measures, as well as other benchmarks. Although programs can take a number of different forms, pay-for-performance models are based on a common set of design elements:

- Performance measurement
- Incentive design
- Transparency and consumer engagement

Performance target: A performance target is a specific, planned level of a result to be achieved within an explicit timeframe with a given level of resources.

Performance benchmark: A performance benchmark is a tool used to measure the performance of an organization's products, services, or processes against those of another similar organization considered to be best in class.

Performance improvement project: A performance improvement project establishes a planned, systematic, organization-wide approach to process design and performance measurement. It also includes measuring the impact of the interventions or activities with the goal of achieving improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, and grievance and appeals processes. These projects are required by the state and can be of the MCO or Pre-paid Inpatient Health Plans choosing or prescribed by the state.

Potentially preventable events: Potentially preventable events are health care services, such as emergency department visits, hospital admissions, and hospital re-admissions, which might have been avoided by providing more timely access to high-quality care in outpatient settings, improved medication management, greater health and health system literacy, and better coordination of care among providers across the system of care delivery and between patients, their families, and health care providers.

Potentially preventable readmission: A potentially preventable readmission is a readmission (return hospitalization within the specified readmission time interval) that is clinically related to the initial hospital admission.

Prepaid inpatient health plan: A prepaid inpatient health plan is an entity that:

- Provides medical services to members under contract with the State Medicaid agency.
- Does not use state plan payment rates on the basis of prepaid capitation payments or other payment arrangements.
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members.
- Does not have a comprehensive risk contract.

Primary prevention: Primary prevention consists of strategies that seek to prevent the occurrence of disease or injury, generally through reducing exposure or risk factor levels. These strategies can reduce or eliminate causative risk factors (risk reduction).

Program: In this document, programs refers to the health and long-term care programs serving particular Wisconsin Medicaid members through managed care, including BadgerCare Plus, Medicaid SSI, Family Care, and Family Care Partnership.

Quality: Quality is defined as how well the health plan keeps its members healthy or treats them when they are sick. Quality health care means doing the right thing at the right time, in the right way, for the right person, and getting the best possible results.

Quality assessment and performance improvement program: Quality assessment and performance improvement is the coordinated application of two mutually reinforcing aspects (quality assurance and performance improvement) of a quality management system. Quality assessment and performance improvement takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving.

Quality measure: A quality measure is a tool that helps to quantify health care processes, outcomes, patient perceptions, organizational structure or systems that are associated with the ability to provide high-quality health care or that relate to one or more quality goals for health care.

Remediation plans: Remediation plans refer to corrections in the intervention or measurement in order to improve outcome.

Secondary prevention: Secondary prevention strategies seek to identify and control disease processes in their early stages before signs and symptoms develop (screening and treatment).

Social determinants of health: Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (for example: social, economic, and physical) in these various environments and settings (for example: school, church, workplace, and neighborhood) are referred to as place. In addition to the more material attributes of place, the patterns of social engagement and sense of security and well-being are also affected by where people live.

Specific, measurable, achievable, realistic, and time-oriented objectives: These are short- to intermediate-term statements that are clear, measurable and specifically tied to a goal. These statements provide a specific, detailed description about the amount of improvement expected in a certain period of time.

Special health care needs: Within the DMS acute care programs, members who require additional assistance for conditions that may be medical, mental, developmental, physical, or psychological are considered to have special health care needs.

Strategies: Strategies are the methods or approaches used to achieve objectives.

Supplemental Security Income (SSI): SSI refers to eligible individuals receiving income through federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind, or have a disability and have household income levels at or below 100% of the federal poverty

level. Individuals receiving SSI may receive health care services through Medicaid SSI or SSI-Related Medicaid.

Target group: In Family Care and Family Care Partnership, individuals must meet at least one of the statutorily defined target groups of physical disability, Wis. Stat. § 15.197(4)(a)2; frail elder, Wis. Admin. Code § DHS 10.13(25m); federal definition of intellectual/developmental disability, 42 C.F.R. § 435.1009 (2012); or state definition of developmental disability, Wis. Stat. § 51.01(5)(a).

Tertiary prevention: Tertiary prevention strategies reduce or prevent disability by restoring individuals to their optimal level of functioning after a disease or injury is established.

Triple aim: The term triple aim refers to the simultaneous pursuit of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.

Vision: An organizational vision is a futuristic view regarding the ideal state or conditions that an organization aspires to change or create.

Wisconsin Medicaid Quality Strategy (Quality Strategy): The Quality Strategy document complies with federal regulations (§ 438, subpart D) and is intended to serve as a framework for the state and its contracted health plans to assess the quality of care that members receive, as well as set measurable goals and targets for improvement.

c. Quality Measure Matrix

The specific quality measures, listed below, are from reference materials linked in Appendix 8g.

i. Acute Care

Pay-for-performance measures for BadgerCare Plus and SSI HMOs:

- Breast Cancer Screen (BCS)
- Childhood Immunization (CIS) – Combo 3
- Comprehensive Diabetes Care - HbA1c Test
- HbA1c Control (<8.0%) - NQF # 0575
- Controlling BP (CBP) - NQF # 0018
- Depression Medication (AMM - Continuation)
- AODA (IET - Engagement)
- Tobacco (Counseling only) – non-health care effectiveness data and information set
- Follow-up after inpatient discharge (FUH30)
- Prenatal and Post-partum care (PPC) – two measures
- ED Visits (AMB) sans revenue code 0456
- Dental Care - Children (ADV + dental care provided by physicians); non-health care effectiveness data and information set
- Dental Care - Adults (similar to children’s measure except for age range and relevant codes); non-health care effectiveness data and information set

Core reporting measures for BadgerCare Plus HMOs:

- Adult BMI (ABA)
- Adult access to preventive care (AAP)
- Adolescent immunization (IMA)
- Children/adolescent access to preventive care (CAP)
- Well-child visits in first 15 months (W15)
- Well-child visits in the Third, Fourth, Fifth and Sixth years (W34)
- Adolescent well care visits (AWC)
- Mental health utilization (MPT)
- Blood lead testing (LSC)

Core Reporting Measures for SSI HMOs:

- Adult BMI (ABA)
- Adult access to preventive care (AAP)
- Mental health utilization (MPT)

SSI Care Management Initiative Measures:

- Care Planning (CP1): percentage of new members had a care plan within 90 days of enrollment

- Needs Stratification (NS1): percentage of members enrolled each month assigned to WICT
- Needs Stratification (NS2): percentage of members enrolled over the year assigned to WICT
- Needs Stratification (NS3): average number of months a member assigned to WICT
- Needs Stratification (NS4): percentage of members enrolled each month assigned to Medium stratum
- Needs Stratification (NS5): percentage of members enrolled over the year assigned to Medium stratum
- Needs Stratification (NS6): percentage of members enrolled each month assigned to Low stratum (equal to combining all strata below Medium)
- Needs Stratification (NS7): percentage of members enrolled over the year assigned to Low stratum (equal to combining all strata below Medium)
- Transition Care (TC1): percentage of discharges who received transition care follow-up
- Transition Care (TC2): percentage of discharges who received transition care follow-up within five business days

Potentially preventable readmission measure: percent reduction in actual to benchmark ratio in the measurement year compared to the baseline actual to benchmark ratio.

Alternative payment model measure: 10 percent threshold target for combined BadgerCare Plus and Medicaid SSI dollars.

Health needs assessment measure (lesser of the following): rate of timely (within two months of enrollment) health needs assessments for BadgerCare Plus Childless adult population.

Health check measure: percentage of the required age-appropriate comprehensive screenings for members under 21 years of age conducted in the measurement year

ii. Long-Term Care

Long-term care program staff provide performance measure data to CMS annually through the CMS 372 report, which identifies the number of people who received home and community based waiver program services and Medicaid expenditures. Public reporting is available on the following measures.

Long-term care in motion measures:

- Enrollment by target group
- Target group enrollment by program
- Enrollment by age
- Enrollment by age, by program
- Current living situation
- Current living situation by program
- Service expenditures by program
- Percentage of member self-directed services by program
- Employment for working age members (18-64)

- Percentage of members receiving influenza vaccine
- Percentage of members receiving pneumonia vaccine

Member satisfaction survey measures:

- Can you contact your care team when you need to?
- How often do you get the help you need from your care team?
- How clearly does your care team explain things to you?
- How carefully does your care team listen to you?
- How respectfully does your care team treat you?
- How well did your care team explain the self-directed supports option to you?
- How involved are you in making decisions about your care plan?
- How well does your care plan support the activities that you want to do in your community, including visiting with family and friends, working, volunteering, and so on?
- How much does your care plan include the things that are important to you?
- Overall, how respectfully do the people who provide you with supports and services treat you?
- How well do the supports and services you receive meet your needs?
- Overall, how much do you like your MCO?
- Currently, which of the following best describes where you live?
- Who answered the questions in this questionnaire?

External quality review annual technical report measures

- Validates quality compliance review
- Validates performance improvement projects
- Validates performance measures
- Information systems capability assessment
- Care management review

d. Summary of Current Enabling Data and Technology Assets

Currently, data and infrastructure technology enabling acute care and long-term care managers and program areas include:

- *Encounters and claims:* BadgerCare Plus and SSI HMOs and Care4Kids must submit compliant encounter data files in a HIPAA compliant ASC X12 transaction format. To do so, they must have a system that is capable of processing claims, submitting compliant encounters, monitoring enrollment and disenrollment, and reporting requirements.
- *Member and provider enrollment:* BadgerCare Plus and SSI HMOs must submit a detailed provider network and facility file, and must use only those providers that have been enrolled with Wisconsin Medicaid. All members in Family Care and Family Care Partnership are enrolled through the state. To qualify for Family Care and Family Care Partnership, the participant must meet both functional and financial requirements. DHS maintains all data on each member enrolled in the program that are collected through the state interChange (Medicaid Management Information System) system, encounter data, and the functional screen.
- *Surveys:* The acute care program area collects periodic information from BadgerCare Plus and SSI HMOs through surveys and uses the CAHPS Survey for members (see DMS Managed Care Programs section). Family Care and Family Care Partnership collect information through the use of an annual member satisfaction survey through an impartial third party.
- *Public and private registries:* The BadgerCare Plus HMOs, SSI HMOs, and Obstetrics Health Home have a self-developed registry, hosted by the external quality review organization, to share information between HMOs, clinics, and DMS acute care program staff.
- *Stakeholder-reported data:* Acute care program staff collect health care effectiveness data and information set-audited measures from HMOs, as well as periodic written reporting and performance data for various programs.
- *ACCESS:* ACCESS is a self-service internet-based application that allows the public to enroll in public assistance programs, including Medicaid, BadgerCare Plus, FoodShare, Child Care, and W-2. ACCESS includes functionality that allows members to screen for benefit eligibility, apply for benefits, check the status of benefits, report a change, renew benefits, and submit documentation. It is available online to citizens 24 hours per day, seven days per week. The ACCESS portal includes the functional screen for long-term care members.
- *Client Assistance for Re-employment and Economic Support System (CARES):* Wisconsin's highly integrated system that uniquely identifies individuals and efficiently shares data across multiple eligibility programs and work programs. The Wisconsin CARES system enables workers in all Wisconsin counties and tribes the ability to perform automated eligibility determination, benefit calculation, and case management for applicants applying for Medicaid (including long-term care and SeniorCare prescription drug program), BadgerCare Plus, FoodShare, Child Care Assistance, TANF, and Caretaker Supplement program.

- *Adult long term care functional screen:* This system is a web-based application used to collect information about an individual’s functional status, health, and need for assistance for various programs that serve the frail elderly, people with intellectual/developmental disabilities or physical disabilities. Wisconsin’s functional screen system was developed using web-based technology and it determines functional eligibility for adult long-term care waiver programs. Experienced professionals, usually licensed social workers or registered nurses who have taken an online training course and passed a certification exam, are able to access and administer the functional screen. The functional screen is completed when someone applies for long-term care services and annually once they are receiving services. The functional screen is also used to establish capitated rate payments annually for MCOs.
- *Medicaid Management Information System:* The ForwardHealth interChange2 is Wisconsin’s multi-payer, web-based Medicaid Management Information System. This system provides claims processing, payment and reporting, provider and managed care enrollment information, coordination of benefits, and other administrative and operational system support to Wisconsin's health care programs, including Medicaid, BadgerCare Plus, Family Care, SeniorCare, Wisconsin Immunization Registry, Wisconsin Well Woman Program, and Wisconsin Chronic Disease Program. ForwardHealth interChange2 was developed using a business model that aligns with the Medicaid Information Technology Architecture Framework.
- *ForwardHealth:* The ForwardHealth Portal uses secure web portal technology to serve providers, managed care organizations, trading partners, and other partners. It provides access to interChange2, depending on the type of user and the user’s specific role. The secure portal allows users to securely conduct business with ForwardHealth as listed below for each user type:
 - The primary areas covered under the secure **provider portal** include: Wisconsin Medicaid EHR Incentive Program, portal messaging, claims, electronic funds transfer, prior authorization, remittance advice, enrollment verification, designation of an 835 receiver, provider demographic maintenance, hospice election, and express enrollment.
 - The primary areas covered under the secure **MCO portal** include: portal messaging, enrollment verification, interChange2 (iC2) functionality, remittance advice, electronic funds transfer, designation of an 834/820 receiver, and trade files and reports.
 - The primary areas covered under the secure **trading partner portal** include: portal messaging, upload and download electronic data interChange2 files, view designations, and create and update profile.
 - The primary areas covered under the secure **partner portal** include: portal messaging, enrollment verification, and interChange2 (iC2) functionality.
- *Electronic health records and patient portals:* Most contracted acute care providers use electronic health records to document health information in digital formats. Provider portals can be connected to electronic health records for acute personal health information and to communicate with providers. Electronic health records systems can also be patient

portals used by health plans to connect with members for billing, care alerts, and other purposes.

- *Care coordination software:* Most BadgerCare Plus and SSI HMOs have technology to help document care coordination and member care plans; however, this software varies by HMO. All Family Care and Family Care Partnership MCOs have and maintain care coordination software to document care provided and to maintain the current member-centered plan. The software varies by MCO.
- *MCO management information system:* Each long-term care MCO must maintain a health information system that collects, analyzes, integrates, and reports data on utilization, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility.
- *Information exchange system:* Long-term care MCOs report data, as requested by DMS, through the information exchange system. In addition to encounter reporting, uses of this system include incident reporting and restrictive measures reporting.
- *Secure file transfer and secure portal:* BadgerCare Plus and SSI HMOs must have a secure ForwardHealth Portal account to access data and reports, maintain information, conduct financial transactions, and other business with acute care program staff.

e. Quality Strategy Public Comments

The draft Quality Strategy document was made available February 20 through April 21, 2018, for comment by stakeholders and the general public through a number of outreach efforts. This included feedback from advisory committees and councils and tribal consultation. The document was published in draft form on the DHS website. Following the 60-day public comment period, all feedback was reviewed and the document was updated, as appropriate. This appendix includes copies of comments received on the Quality Strategy and DMS' response to all comments.

Comments: Verbatim comments can be found below.

Response: DMS appreciates stakeholder feedback related to this Quality Strategy document.

Copies of Submitted Comments

1 The National Committee for Quality Assurance (NCQA) appreciates the opportunity to provide feedback on Wisconsin’s proposed Medicaid Managed Care Quality Strategy. We strongly support the Division of Medicaid Services’ efforts to promote quality oversight for both acute and long-term managed care programs. We have included our comments and recommendations below.

1) Accreditation Deeming

We applaud the Division of Medicaid for streamlining administrative processes for NCQA Accredited plans and including the provisions to implement accreditation deeming pursuant to §438.360 related to non-duplication of external quality review activities in the Quality Strategy. As you implement, NCQA will provide the following support:

- **Validate** the Medicaid MCO’s in Wisconsin with NCQA Accreditation reports.
- **Share** NCQA’s Medicaid Managed Care Toolkit, which the state can leverage to identify deemable standards, as well as gaps (areas outside of the scope of accreditation), which will need to remain part of the state’s HMO oversight process. Annually, NCQA updates this toolkit to reflect alignment of the current NCQA Accreditation standards with MMC deemable provisions.
- **Support** the Wisconsin Division of Medicaid quality team with NCQA Accreditation standards interpretation through our Policy Clarification Support (PCS) system.

2) Leveling the Playing Field: Accreditation for all plans

As you consider policies to enhance quality oversight for acute and long-term care plans, we recommend including expectations for NCQA Health Plan Accreditation as well as LTSS Distinction for all contracted plans. Three states with MLTSS programs (Virginia, Pennsylvania and Kansas) have these comprehensive accreditation requirements now. NCQA Distinction for LTSS serves as an extension to Health Plan Accreditation and provides a standardized framework for holding plans accountable for effectively managing care for this vulnerable population. This recommendation translates to Wisconsin plans in the following way:

- BadgerCare Plus & SSI HMOs (*Acute Plans*)
 - Obtain NCQA Health Plan Accreditation.
- Family Care and Family Care Partnership MCO’s (*Long-Term Care Plans*)
 - Obtain NCQA Health Plan Accreditation *and* NCQA Distinction for LTSS.

What is NCQA Health Plan Accreditation? (for both acute and long-term care plans).

NCQA Health Plan Accreditation is the most comprehensive accreditation program in the nation. Twenty-five state Medicaid programs require NCQA Health Plan Accreditation as a condition of participation (Refer to Appendix A). The program supports plans in delivering high quality care and gives state regulators and health care purchasers the tools to enhance oversight of the insurance they sponsor. The program includes review of the following: quality improvement (QI); credentialing (CR); utilization management (UM); members’ rights and responsibilities (RR); population health management (PHM); and network adequacy (NET).

- **National Program.** More than 169 million Americans—72% of all insured—are in plans accredited by NCQA.
- **Wisconsin Medicaid Carriers Have Experience with NCQA Accreditation.** Six Medicaid plans are currently NCQA Accredited and many more have accreditation for their Commercial, Medicare or Marketplace product (Refer to Appendix B).
- **Only Performance-Based Accreditation.** NCQA Accreditation is the only assessment that scores the quality of clinical care (HEDIS) and patient experience (CAHPS), and requires strict auditing to ensure accuracy. Other programs merely assess whether plans have these critical policies on paper. Performance-based accreditation ensures apples-to-apples comparisons among plans.
- **Multiple Survey Options Available.** NCQA offers a glide path to support smaller plans and those new to accreditation to help build performance measure reporting. The glide path requires plans to report on HEDIS and CAHPS by year 3.
- **Supports State and Federal Oversight.** Including expectations for acute plans to obtain NCQA Accreditation will allow the state to fully maximize Accreditation Deeming and promote oversight efficiencies.
- **Opportunity to Link to Value-Based Payment.** As the state looks to promote value-based payment, there is an opportunity to link enhanced payment with NCQA Accreditation. Many states employ this strategy, including Tennessee and New Jersey.

What is NCQA Distinction for Long-term Services and Supports? (for long-term care plans).

NCQA’s Distinction for LTSS is designed to support NCQA-Accredited health plans and managed behavioral health organizations that provide medical/behavioral health benefits and coordinate LTSS. The program includes review of the following: core features, such as person-centered assessments and implementation; measuring and improving performance; care transitions; and delegation of LTSS.

- Standardizes model of care for plans and MBHO’s managing and coordinating LTSS.
- Serves as an extension to NCQA Health Plan Accreditation.
- Aligns with the LTSS provisions within the 2016 Medicaid Managed Care rule.
- Demonstrates commitment to integrate care and improve outcomes for this special population.

3) Additional LTSS Oversight Option – NCQA Accreditation of Case Management for LTSS

We encourage the state and its contracted plans to work with community-based organizations to become accredited and demonstrate their preparedness for delivering LTSS services in coordination with managed care plans.

NCQA Accreditation of Case Management for LTSS provides a framework for community-based organizations to deliver efficient, effective and person-centered care, which includes evaluation of the following: conducting comprehensive assessments, managing care transitions, performing person-centered assessments, and planning and managing critical incidents.

Resources & Next Steps

NCQA is extremely supportive of the state’s efforts to build accountability within the Wisconsin Medicaid managed care model and hope to be a valuable resource as you think through critical quality oversight policies and functions.

Should it be helpful, we would be happy to send a physical copy of NCQA Health Plan Accreditation program standards and electronic copies of the LTSS program requirements.

We would welcome the opportunity to discuss these ideas in greater depth. To coordinate, I can be reached at Toppe@ncqa.org or 202-955-1744.

We look forward to hearing from you.

2

Thank you for the opportunity to comment on the Division of Medicaid Services' proposed metrics for its Medicaid Managed Care Quality Strategy. Per your request, the Wisconsin Family Care Association's recommendations regarding metrics are as follows.

LTC Goal #1 Promote efficient and cost effective services and supports through innovation, standards, data-driven quality, and evidence-based practices.

- Increase the number of P4P measures included in each LTC MCO contract.
 - **WFA Metric Recommendation:**
 - Track the number and percent of capitation at risk in P4P year-over-year. To ensure that MCOs are receiving adequate funds to provide quality services and supports.

LTC Goal #2 Focus on the whole person including their physical, psycho-social, and spiritual needs to live and work freely in their home and community.

- Increase the % of FC and FC-P members who live in a private residence (home, family home, apartment, etc.) –
 - **WFA Metric Recommendations:**
 - LTC Functional Screen (point-in-time has a section of where the person lives)
 - Encounter data (residential & institutional utilization)
 - National Core Indicator (NCI) data
 - Possible member satisfaction question
- Increase the rate of competitive integrated employment of FC and FC-P members who want to work.
 - **WFA Metric Recommendations:**
 - Need clear data on who wants to work (this information is being gathered in our member assessment)
 - LTC Functional Screen (point in time – identifies the people that are working and where they are working)
 - MCO reportable to DHS (this can be defined to meet the intended outcomes)
 - DVR referrals (track utilization of DVR services) and efficacy (track DVR case closures)
 - PPS data
 - EQRO CMR measures
 - Encounter data

LTC Goal #3 Empower people with access to an array of services and supports.

- Reduce the IMD length of stay of FC and FC-P members after they are determined psychiatrically stable.
 - **WFA Metric Recommendations:**

- MCO reportable data to DHS (clearly define psychiatrically stable and then can add a column to the IMD tracking spreadsheet)
- Establish a valid sample size for the measure and then establish a baseline in the industry and by MCO, target % improvement annually.

LTC Goal #4 Ensure continuous improvement of high quality programs to achieve people’s identified goals and outcomes.

- Increase the % of service plans that address FC and FC-P member’s assessed needs and personal goals.
 - **WFCM Metric Recommendation:**
 - CMR data (need to define what personal goals are)
- Increase the % of FC and FC-P members for whom services as identified in the MCP were implemented consistent with the plan.
 - **WFCM Metric Recommendation:**
 - EQRO CMR data

LTC Goal #5 Engage people who have meaningful choices about where and with whom they live, their services, and who provides them.

- Increase the % of FC and FC-P members who self-directed at least one service in their care plan.
 - **WFCM Metric Recommendations:**
 - MCO reportable data to DHS (Need clear definition of self-directed - is this only paid or could it include natural support?)
 - Encounter data, could look to add a modifier for SDS if needed
 - EQRO CMR
- Increase the % of FC and FC-P subcontractor compliance standards that are in compliance with provider selection and retention standards set by DMS.
 - **WFCM Metric Recommendations:**
 - DQA survey results (for licensed facilities)
 - MCO reportable based on QM for contract compliance
 - DHS provider audit results
 - EQRO audit
 - Provider network certification process
- Increase the % of FC and FC-P members who report living in the setting they prefer.
 - **WFCM Metric Recommendations:**
 - LTC Functional Screen – (exclusions for people who are protectively placed and don’t want to be here or temporary placement in SNF for rehab)
 - Member survey (could add this as a question)
 - EQRO CMR results

- Appeal and grievance data
- NCI data

LTC Goal #6 Empower consumers to make informed choices.

- Offer a wider range of relevant data to consumers (ex. Member satisfaction survey results, P4P results, IDT staff ratios and turnover, information about sanctions, etc.) in FC and FC-P.
 - **WFOA Metric Recommendations:**
 - flu/pneumonia stats and education,
 - size of membership,
 - CMR (results),
 - QCR (results),
 - PIP (activities and results),
 - fiscal ratios,
 - network adequacy results (ensure that there is a consistent measurement that is determined across the industry), and
 - certification status (identify if there are any concerns or not with annual certification)

Please don't hesitate to contact us with any questions. We look forward to discussing the state's quality strategy and our recommendations in more detail.

3

Thank you for the opportunity to comment on the Division of Medicaid Services' (DMS) proposed Medicaid Managed Care Quality Strategy.

The Wisconsin Family Care Association, which is made up of five of the Managed Care Organizations (MCOs) providing Medicaid managed long-term care services to Wisconsinites, appreciates DMS' commitment to collaboration and stakeholder input. Our Wisconsin-based MCOs have provided high quality long-term care services for nearly 20 years. We are very proud of the fact that once Family Care is fully implemented statewide, Wisconsin will be one of the first states in the nation to end waiting lists for adult long-term care.

WFOA is committed to working with the DMS to continuously improve member outcomes through the delivery of high quality care while identifying and implementing changes that will improve cost effectiveness. We look forward to working collaboratively with DMS to develop a vision for the future of long-term care in Wisconsin.

WFOA has several over-arching comments on the proposed quality strategy.

1. We seek more information on the types of baseline data and proposed benchmarks which DHS will use to track progress on their proposed quality measures. We hope that stakeholders will have input into the development of these two pieces of data.

2. WFCAs believe that quality improvement policies and goals should be consistent across long-term care programs. We seek clarity on what types of quality and performance improvement measures will be implemented for the IRIS program.
3. Member Choice is one of the founding principles for our Medicaid managed long-term care system. We must ensure that member choice is honored and reflected throughout our quality strategy, especially in our benchmarks and sample sizes.
4. MCO pay-for-performance (P4P) efforts hold the promise of improving quality outcomes for members. WFCAs believe it is critical that P4P initiatives capitalize on evidence-based practices, cycles of implementation and methodologies that have been developed in both the acute and primary care space and in other states.

WFCAs offer the following specific comments on the draft Medicaid Managed Care Quality Strategy.

Access to Care and Member Choice

Reduce the Length of Stay of Family Care and Family Care Partnership members in institutions for mental disease after the member is determined psychiatrically stable.

A significant, state-wide shortage of psychiatrists has contributed to the challenge of keeping individuals with serious and persistent mental illness stable in community settings. This shortage has lengthened stays at state psychiatric hospitals where members remain until a community psychiatrist is identified and an appointment is scheduled. This negatively impacts transition of care. WFCAs recommend the following solution: Through the use of telemedicine, enable state psychiatric hospital doctors to continue to provide psychiatric care to Family Care members for up to 60 days following discharge from an IMD. This would ensure continuity of care and increase the likelihood of a successful transition thereby reducing readmissions to the IMDs.

The admission of a Family Care member into an IMD and the subsequent transition back into the community involves multiple state systems. Each of these stakeholder groups has different legislative and program pressures tied to the outcome they are trying to or are expected to reach. Due to this complexity, WFCAs suggest that any quality initiatives implemented to affect outcomes related to IMD admissions focus on cross-system changes with accountability across stakeholders and not just focused on MCOs and the long-term care system.

WFCAs also seek clarification on the proposed baseline and benchmarks for this item as they are not listed in the quality strategy. We ask that these be developed with stakeholders.

Implement legislative initiatives to promote access to care.

Any proposed legislative initiatives should be developed in collaboration with MCOs. The in-depth operational and real world experience that MCOs have with the Family Care and Partnership programs is invaluable.

WFCAs suggest the following policy ideas that could promote access to care:

Reduce administrative burdens on care teams so that more time can be spent with the member.

- Increase the use of technology and telemedicine.
- Encourage innovation in service provision through flexible coding and regulation. Monitor and share promising and/or best

practice across the industry.

- Decrease barriers to and build incentives for Acute and Primary Care Providers to support access to Electronic Medical Records for MCOs.
- Make the direct care workforce funding provided by the 2017-19 state budget a part of DHS's base budget to ensure ongoing funding.

Cost-Effectiveness

Increase the number of pay-for-performance measures included in each long-term care contract.

WFCFA supports pay-for-performance. It is our understanding that only a few states have adopted pay-for-performance or other alternative payment arrangements for long-term care. MCOs must be involved in the in the design and development of any alternative payment models. Piloting and testing of any new proposed pay-for-performance metrics is critical to prevent unintended consequences. In addition, it is our understanding that within the BadgerCare and SSI Managed Care programs, HMOs can earn pay-for-performance funds in two ways:

1. Level targets, which are designed to recognize and give credit to HMOs with already high performance.
2. Degree of Improvement targets, which are designed to recognize HMOs that are below the Level targets but making improvements in their performance.

WFCFA recommends that a similar two-track method be adopted for Family Care and Partnership pay-for-performance. Since pay-for-performance funding is being funded through a capitation payment withhold from Family Care and Partnership MCOs, WFCFA asks that any funding not used in the pay-for-performance pool remain in the pool instead of being lapsed back to DHS. This will ensure that Family Care funds stay within the Family Care system.

Person-Centered Care and Member Experience

Increase the percentage of Family Care and Family Care Partnership members who live in a private residence.

Capacity needs to be developed within Wisconsin communities to support affordable and accessible private housing for people with disabilities.

Any plans to monitor MCO progress on increasing the rate of members who live in private residences must also reflect member choice.

Increase the rate of competitive integrated employment of Family Care and Family Care Partnership members who want to work.

WFCFA supports efforts to increase employment for Family Care and Partnership members. One of the biggest challenges to supporting Family Care and Partnership members in achieving competitive employment is a lack of community and employer awareness of this underutilized workforce, particularly in rural areas of the state. Work must be done to build awareness and develop the infrastructure needed to employ individuals with disabilities who want to work in the community. The Wisconsin State Legislature has recognized these challenges and recently passed legislation to provide a small amount of grant funding for community development. Additional funding is needed. This will not only increase the employment opportunities for individuals with disabilities, but also build a stronger and more

diverse workforce in Wisconsin.

Plans to monitor the progress of MCOs in increasing integrated employment must take the variation in job markets across the state into account and ensure that the sample size is individuals who want to and are able to work.

A focused and purposeful approach to assisting provider organizations to transform their service delivery model to one that prioritizes community-based employment will be essential to support systems change and meet the outcome to increase Community Integrated Employment. This will need to be supported through all levels of the systems (Legislative, DHS, MCOs, DWD, Advocates, etc.).

Increase the percentage of Family Care and Family Care Partnership members who self-direct at least one service in their care plan.

The 2015 Long Term Care in Motion Report indicates that approximately 1 in 5 Family Care and Partnership members self-direct at least one service. The 2015 member satisfaction survey reported that 61% of members reported being given the option to self-direct some or all of their services within the past 12 months.

Plans to monitor MCO progress on the number of members who self-direct must take into account member choice. Not all members want to or are able to safely self-direct.

Raising awareness of the ability of Family Care and Partnership members to self-direct is critical to achieving success on this metric. There needs to be increased awareness at ADRCs on what SDS options in Family Care are, and can look like for, potential MCO members. DHS could also consider ways to highlight self-direction in Family Care and Partnership through the sharing of success stories or other educational initiatives.

Increase the percentage of Family Care and Family Care Partnership subcontractors with standards that are in compliance with provider selection and retention standards set by DMS.

WFCA is in agreement that there need to be quality standards and vetting/credentialing associated with Provider Networks. WFCA encourages DHS to review current processes to meet this outcome, and assure there is not duplication within the system to achieve this. Currently there are multiple processes and agencies completing similar, if not the same, oversight for the same providers. For example, some residential provider types: MCOs, BALTC, and DQA are providing oversight for the same thing simultaneously. External Quality Reviews being conducted by Metastar provide very similar reviews of MCOs selection and retention standards as the BALTC provider audits do. Duplicative reviews leverage a lot of resources across the system that could be focused on other value-added activities.

Increase the percentage of Family Care and Family Care Partnership members who report living in the setting they prefer.

The 2013-15 Long Term Care Scorecard Report indicates that 12% of long-term care recipients report that they would prefer to change their living situation and only 7% of enrollees reported wanting to move to a less restrictive setting. WFCA requests clarification on the proposed benchmarks for this measure as it appears that the vast majority of Family Care and Partnership members are already living in their preferred setting.

Health Outcomes and Reducing Disparities

Increase the percentage of Family Care and Family Care Partnership members for whom services, as identified in the member-centered plan, were implemented consistently with the plan.

Baseline development will be critical for this metric. Clear criteria will need to be developed with stakeholders, DHS and AQR for interrater reliability and consistency across MCOs.

Enabling Infrastructure: Data and Technology

DMS is interested in implementing a robust, enterprise-wide health information technology infrastructure that may involve digitizing data and processes, making electronic data (for example: claims, performance monitoring data) available to HMOs and providers, accessing and integrating clinical and administrative data, and analyzing this data for payment, results, and insights. DMS will conduct an assessment of the current state of enabling technology and develop a future state health information technology and data implementation plan to enable successful execution of strategies.

This would be a significant project with multiple years of development. Stakeholder involvement will be critical to the development of a value-added IT infrastructure within Wisconsin's Long Term Care System.

Accelerate Quality Monitoring

To support implementation of the strategies outlined in this document and assessment of progress toward goals and objectives, the future data and technology plan will establish a robust electronic quality measurement system.

We must ensure that any changes to data systems do not lead to increased administrative burdens for MCOs. Increased administrative burdens related to data collection pulls resources away from continuous improvement efforts.

Use Technology to Engage Members

DMS aims to use health information technology enablers to help HMOs and MCOs proactively share information with members about their health status and delivery and quality of care; and encourage members to interact with HMOs, MCOs, and their providers about their care. This could include greater use of telehealth, remote patient monitoring, member education, and other tools to engage members in their care.

MCO input into the process and opportunity to contribute is critical in any IT efforts, particularly related to engaging members. There are options available for telehealth.

Thank you for the opportunity to provide input on the state's quality plan. Please don't hesitate to contact us with any questions. We look forward to discussing the state's quality strategy and our recommendations in more detail.

4 Good afternoon, we at UnitedHealthcare, have reviewed the draft version of the Wisconsin Medicaid Managed Care Quality Strategy. We are fully supportive of DHS's goal of having more alternative payment models in the Wisconsin Medicaid program. We are actively involved in these arrangements with providers in other markets, and we are in the early stages of introducing some arrangements in Wisconsin. However, as we have discussed previously with DHS, we have concerns with the 10% threshold due to the currently proposed

	<p>definition of how the ratio is calculated. We would like to continue the discussion with DHS on how to best define the program (and thresholds) by bringing some of the experiences we have gained in other markets. We look forward to discussing with DHS in the near future.</p> <p>Should you have any further questions, please do not hesitate to reach out to me.</p>
5	<p>iCare's Medicaid Managed Care Quality Strategy Guide Comments</p> <ol style="list-style-type: none"> 1) On p. 4 it states that while the Quality Strategy is specifically focused on Wisconsin Medicaid members receiving acute and/or long-term care services, the quality goals apply to all programs in which Medicaid member are enrolled, including fee-for-service members. Will there be public comment on those as well? 2) This document does not recognize that Family Care Partnership MCOs are responsible for primary and acute services. 3) High quality health care is referenced repeatedly in the document? What does that mean and how will HMOs/MCOs quantify this? 4) Social Determinants of Health Care is defined on p. 55. In the final version of the Quality Strategy Guide will this definition be further defined or remain broad in definition? 5) How are health disparities being referenced in the context of this document? <ol style="list-style-type: none"> a. Can HMOs/MCOs expect to receive criteria surrounding various health disparities? b. how can HMO/MCOs track this accurately when there is a high churn rate? 6) HMOs/MCOs are being held accountable for post discharge readmissions but there is a disconnect between the providers and the HMOs/MCOs responsibility within this process. Will there be an increased emphasis on provider accountability within this process? 7) Will there be an increased push for data sharing and inpatient notification to the PCP by the health systems? 8) P. 21 DMS will also create requirements for effective care coordination and management, starting with SSI HMO members, that will help improve care, health outcomes, and experience of care for the members, and will ensure appropriate utilization of services. Is there an anticipated release date for these requirements? Will there be HMO input prior to effective date? 9) Will DHS pre-certify the Health Homes or would that responsibility fall on the HMO/MCO? 10) Is there a reference that HMO/MCOs can utilize to determine what requirements for the different types of health homes? If so what is that reference? 11) Will there be further clarification as to how Health Homes are funded? 12) What is the timeframe for a HMO/MCO to get an online health portal up and running? 13) Will the online health portal that HMO/MCOs maintain be for members and/or providers? 14) There are references to report cards within this document. Are the report cards for providers and/or members and will there be a template(s) provided to HMO/MCOs? 15) Waiver 1115 is referenced within, what additional activities would the HMOs required to complete in accordance to this Waiver?

- 16) P.38 acute care, third bullet, does underutilization still mean P4P or PCP? Can this be further clarified?
- 17) P. 38 will there be further clarification as to what the expectations for HMOs will be in regard to Restrictive Measures?
- 18) DMS Cultural Competency committee are HMOs invited to participate?
- 19) P. 58 transitions of care TC2 percentage of discharges who received transition of care follow-up within five days. Can this be updated within the document to say “five business days” so it aligns with the contract?

6 On behalf of Aurora Health Care (Aurora), we appreciate the opportunity to submit comments regarding the proposed the strategies for assessment and quality improvement of managed care services offered to Medicaid beneficiaries. As Wisconsin's largest Medicaid provider with many critical access points throughout the state, we are uniquely situated to inform this discussion. This document provides formal input on behalf of our organization, which includes 15 hospitals, more than 150 clinics, and over 33,000 caregivers - -who see more than 1.2 million unique patients annually in our state. Thank you in advance for your consideration of this feedback.

The Quality Strategy outlines the plan that the State Department of Health Services (DHS), through the Division of Medicaid Services (DMS), will use to align programs to best meet the health care needs of Medicaid members in Wisconsin. DMS is taking a broad view of quality that includes improving access, member choice, health equity, promoting efficient and effective care, focusing on patient-centered care and clinical outcomes, and employing principles of evidence-based continuous quality improvement.

Aurora agrees with the need to see continuous evolution within Medicaid in order to better meet the needs of Wisconsinites, but respectfully submits comments on the following aspects of the proposal.

Specificity Needed in Quality Measures - Aurora appreciates the willingness of DMS to solicit and consider feedback from stakeholders and members of the public on this vital issue. We agree that measurements such as potentially preventable readmissions are a useful method for measuring quality. However, the proposal lacks detail regarding how such a standard would be implemented. We suggest that DMS include explicit information about how the quality measures may and may not be used by HMOs, and allow for additional stakeholder comment in the future.

Addressing Health Care Disparities - Related to the point above, the methodology laid out in the proposed strategy does not specify exactly how DMS will advance practices that address the social determinants of health derived, for example, from a patient's geography or socio-economic factors. As an integrated system with a large footprint in Wisconsin, we see first-hand how these variables impact the patients we serve from one region to another. While we applaud DMS for acknowledging this issue as part of the overall strategy, it should be specifically addressed as a component of the quality methodology. Otherwise, this plan could inadvertently penalize those providers who remain committed to serving the most vulnerable and most in need - the very population DMS seeks to help.

	<p><i>Care Coordination</i> - The Quality Strategy emphasizes the importance of care coordination services, continuing the policy of placing these responsibilities at the HMO level. However, the current HMO-led care coordination system is fragmented and inefficient. Barring any willingness to vest this responsibility with providers, who necessarily have direct contact with patients in their medical home, we suggest that the Department play an active role in aligning care coordination efforts among all stakeholders to reduce confusion and inefficiency.</p> <p>Aurora sincerely appreciates this and future opportunities to provide expertise and input on these changes that will impact the patients we serve.</p>
7	<p>Oconomowoc Residential Programs, Inc. (ORP) submits these comments in response to the draft Medicaid Managed Care Quality Strategy (the Draft) prepared by the Division of Medicaid Services, Wisconsin Department of Health Services.</p> <p>Who We Are</p> <p>ORP brings the perspective of more than thirty years of experience providing Long-Term Services and Supports for individuals who have Intellectual or Developmental Disabilities (I/DD) and who now are supported under Family Care. We offer services through four affiliates: Homes for Independent Living of Wisconsin, Prader-Willi Homes of Oconomowoc, Paragon Community Services, and Genesee Lake School.</p> <ul style="list-style-type: none"> • Homes for Independent Living of Wisconsin (HIL) supports 437 individuals enrolled in Family Care. They live in community settings throughout 12 counties in Northeastern, Southeastern, and Central Wisconsin. HIL specializes in serving people with high behaviors, and those with significant physical and cognitive needs. • Prader-Willi Homes of Oconomowoc (PWHO) is the nation's largest provider of residential services and supports for people with Prader-Willi Syndrome, a rare genetic disorder characterized by issues with emotional regulation, difficult behaviors, and life-threatening metabolic symptoms. Along with clients from other states, PWHO supports 33 individuals who are funded by Family Care and who live in or near Waukesha County. • Paragon Community Services (PCS) offers day programs and community respite to 266 members of Family Care at five locations in Northeastern and Southeastern Wisconsin. 92 of those individuals are also supported in HIL residential settings. Genesee Lake School (GLS) is a national leader in providing therapeutic services for children with developmental disabilities and behavior disorders. Five of its students, between 18 to 21 years of age, are supported by Family Care. <p>Together, ORP affiliates offer services to 649 Family Care members, empowering them to live their best lives in the community. This represents about 3% of the I/DD population enrolled in Family Care. ORP does not provide Acute Care services. We appreciate the opportunity to provide input on those sections of the Draft that relate to quality improvement strategies for Wisconsin citizens who are in the I/DD classification and who are supported by Medicaid.</p> <p>Summary</p> <p>1. <i>Recommendation #1:</i> A reduction in length of stays for Family Care members in Institutions for Mental Disease is feasible, but will require better alignment of: financial incentives, a heightened focus on discharge planning, and enhanced provider</p>

capacity.

2. *Recommendation #2:* Caution should be exercised regarding the expansion of untested Pay for Performance mechanisms tied to surveys of members in Long-Term Care settings.

3. *Recommendation #3:* There should be alignment between the Medicaid Managed Care Quality Strategy overseen by DMS, and quality goals developed by the Division of Quality Assurance for Long-Term Care settings.

4. *Recommendation #4:* There continues to be a compelling case for legislative reform that would integrate Acute Care and Long-Term Care, at least for high-cost Medicaid populations.

Domain 1: Access to Care and Member Choice

Recommendation #1: A Reduction in Length of Stays for Family Care Members in Institutions for Mental Disease Is Feasible, But Will Require Better Alignment of Financial Incentives, a Heightened Focus on Discharge Planning, and Enhanced Provider Capacity. Under the Long-Term Care section of the domain of Access to Care and Member Choice, the very first stated objective in the Draft is to "Reduce the length of stay of Family Care and Family Care Partnership members in institutions for mental disease after the member is determined psychiatrically stable."

HIL has substantial experience in supporting people who present significant behaviors and who have experienced one or more episodes of care in Institutions for Mental Disease (IMDs). We have demonstrated that we can deliver the person-centered supports and sustainable behavior plans that will reduce significantly the likelihood that individuals with a history of institutionalization will return to those settings. A typical profile of an individual in this category might include very complex disorders, significant trauma background, a history of failed placements in multiple settings, one or more periods of institutionalization, and provider staff burnout. In 2017, 106 of the people HIL supplied were Family Care members in this group.

Last year, we made great progress toward our goal of offering these individuals a permanent place to live their best lives:

- 100 of the 106 behavioral clients (94.3%) experienced zero days of placement at an IMD.
- Collectively, this group spent 99.4% of their days either supported by HIL or on home visits (31,756 days in placement versus 190 days of IMD confinement).
- HIL continues to support two of the six clients who experienced IMD placements. We would have continued to support the other from individuals but for factors beyond our control (the client returned to jail for a probation violation, or there was a rate disagreement).
- 91.7% of the behavioral clients supported at any time in 2017 were still supported on December 31, 2017.
- For some clients, HIL has succeeded in reducing the number of staff hours compared to when they were first admitted, or has supported their transition to a less restrictive setting. We achieved this-and thereby lowered rates-for 17 individuals last year.

This success did not happen overnight. We have worked closely with DHS over the years to address gaps in the "ecosystem" of Long-Term Care that can lead to preventable and unnecessary episodes of institutionalization.

For example, we developed a crisis program in Brown County that offers more intensive supports so that individuals with high behaviors can stabilize before relocating to a more permanent place to live in the community. We collaborated creatively with DHS and Care

Wisconsin to identify and overcome obstacles to creating a setting that would offer better services. The program now serves as a critical safety net to prevent unnecessary stays in institutions, thereby improving the quality of care but at lower cost. There are other ways to reduce length of stays in IMDs by members of Family Care. But we see three current barriers to making this happen: **funding incentives, communication, and capacity.**

First, the **financial incentives of government and private stakeholders are not aligned** in a way that would encourage transfer of a Family Care member from an IMD to a less restrictive setting as soon as treatment is complete. In general, Medicaid will not pay for member stays in institutions. "When the individual enters the IMD, he or she is disenrolled from Family Care and becomes the financial obligation of the county of residence. An uncomfortable truth is that it can be in the MCO's financial interest for the member to remain in the IMD.

Second, there are **glaring communications gaps around planning for ultimate discharge**, that delay transitions for Family Care members from the IMD. The dialogue about where the member will go when treatment is complete often does not even begin until shortly before discharge is scheduled. At that point, a mad scramble ensues to locate an appropriate provider.

This points to a third barrier: **provider capacity.** Family Care members who require treatment at IMDs present challenging conditions and behaviors. Few if any providers can afford to hold placement spots open and unreimbursed, just in case they are asked to accept emergency placements of these individuals. Although HIL's crisis program offers transition services, its capacity is limited. Our ability to step down support from crisis level to a traditional community setting can be constrained by the lack of available beds and the need to develop new programs for those individuals.

Several steps could be taken that would reduce the number and length of IMDs stays by Family Care members:

- First, data on the number of Family Care members who are enrolled in IMDs should be shared, to allow a spotlight on the issue and to enable interested parties to see clearly the scope of the problem.
- Second, a group of stakeholders should be convened to discuss ways that financial incentives could be more closely aligned, consistent with federal and state regulations. Providers should be included in these conversations, as we know firsthand the types of supports that these individuals need to be successful-and the snowball effects that occur when they decompensate.
- Third, a best practice should be implemented at IMDs that planning for discharge will begin immediately upon admission, not placed on hold until the client is ready to leave the facility. Someone should be identified as the "owner" of the task of securing the next placement for the member. In those rare situations when an HIL client is referred to an IMD, we inform the Care Team that that we will accept the member into our program following the conclusion of treatment. Family Care service providers should indicate, upon admission, whether they will be able and willing to accept the member upon discharge. If the provider cannot do so, conversations could immediately begin around other possible providers, to promote the likelihood of a seamless transition to a community setting.
- Fourth, the stakeholder group should consider ways to expand capacity. There is a need for additional crisis programs that can

serve as stabilizers in the support system for these members, and that would prevent unnecessary IMD admissions. A method should be considered to dedicate some community settings so that there could be more flexibility when a discharge of a Family Care member from an IMD is imminent.

Prolonged lengths of stays at IMDs are expensive, ineffective, and harmful to Family Care members. To make progress, a work group should be convened that includes representatives of all affected stakeholders, that could be tasked with examining root causes for the level of IMD stays. These could include funding levels and restrictions; availability of and reimbursement for appropriate housing in the community; training for providers in serving the unique needs of this population; and the ability of providers to recruit and retain a qualified work force in this competitive environment.

Domain 2: Cost-Effectiveness

Recommendation #2: Caution Should Be Exercised Regarding the Expansion of Untested Pay for Performance Mechanisms Tied to Surveys of Members in Long-Term Care Settings.

DMS lists a single objective for Long-Term Care under the domain of Cost Effectiveness: to "[i]ncrease the number of pay-for-performance measures included in each Long-Term Care MCO contract."

To be sure, the shift in Medicaid Managed Care reimbursement methodology from Fee for Service (FFS) to Pay for Performance (P4P) and ultimately Value Based Reimbursement (VBR) is accelerating nationwide. This initiative is especially gaining steam in services reimbursed under Medicare. There, the federal Center for Medicare & Medicaid Services has been highly prescriptive. It has issued detailed quality measurement requirements-with respect to survey content, P4P for designated medical procedures in acute care settings, and penalties for poor quality. By contrast, under Medicaid, the states have wide discretion to decide how they will go down the path toward P4P, for which populations, and at what pace.

Long-Term Care for individuals with I/DD poses a special challenge for value-based reimbursement models. Needs of Family Care members with I/DD vary widely; person-centered settings are quite diverse; many providers serve a small number of members; and providers lack the technology infrastructure that the federal government has promoted (and paid for) on the Medicare side. The Long-Term Care I/DD industry is not as advanced as Acute Care providers in reaching a consensus on universal measures of service quality, that can support evaluations of quality across provider settings and over time.

DHS is making its first foray into Family Care P4P in 2018. This year, contracts with MCOs include a P4P mechanism that will be based on measures of member satisfaction. Scores on four survey questions will determine the results. Up to 0.5% of an MCO's capitation revenues will be withheld if performance on the member surveys is below minimum expectations, while exceptional performance could generate 0.5% on top of normal capitation levels. Because the MCOs can keep a maximum of 2.5% of their capitation revenue, the variable amount of 0.5% in fact represents 20% of the total they can retain, with a swing of up to 40% between high performers and low performers.

Questions remain about this program. To cite a few:

- The content of some questions may make it difficult for members to distinguish between services provided by the MCO versus providers of other services. Question 4 in the survey is: "How well do the services you receive meet your needs?" A disgruntled member may be unhappy, but may not clearly distinguish among services provided by the MCO, by the residential provider, the day services provider, the Care Team, or all the above. This could skew the survey results.
- The frequency scale for responses on the question above consists of: "Not at All; A Little; Somewhat; Very; Extremely." It is not clear that there is a statistically valid difference between the response of "A Little" versus "Somewhat."
- Financial penalties and incentives will be directly related to the number of positive responses (minimum performance standard) and top response (target performance benchmark). DMS enlisted the assistance of the University of Wisconsin Survey Center to develop the survey questions. We do not yet know whether there will be a statistically valid relationship between survey responses and the quality of care and service delivered by the MCO.

We do not challenge the underlying philosophy that supports P4P. But there needs to be recognition that the quality measures for Long-Term Care industry in Wisconsin are much less developed than in Acute Care. The results of this first effort at P4P in Family Care should be examined closely before DMS doubles down on tying payments to survey results.

In the meantime, the Long-Term Care industry could take a step forward if it could achieve consensus around the member experience survey to be used for I/DD individuals served under Family Care.

One source could be the National Core Indicators (NCI). The Draft states that Family Care members who are included in the NCI I/DD target group may be selected to receive an NCI survey. The Core Indicators are standard measures used across states to assess the outcomes of services provided to these individuals and their families. Some of the questions in the NCI questionnaire could be assembled into an assessment tool that would be an appropriate measure of Family Care member experience. HIL uses a client survey that includes such questions; a sample is included as an Appendix to these comments.

Note that the primary purpose of the National Core Indicators survey is to measure and compare the performance of state agencies, like DHS, that administer Long-Term Care plans for the I/DD population, not to assess individual Managed Care Organizations or service providers. NCI imposes certain requirements to ensure that the results are statistically valid, which would not transfer well to provider surveys. So, the survey would have to be adapted with the appropriate outside expert guidance.

Another possibility would be to examine the Net Promoter Score (NPS). The NPS relies on a simple question to assess customer satisfaction: "How likely is it that you would recommend the service provider to a friend or colleague?" Answers are given on a scale of 0 to 10, and the result is calculated in a way that weeds out everyone who is not extremely enthusiastic about the provider. NPS has been

the subject of numerous research studies, across many industries, that prove it provides a statistically valid indicator of customer behavior and organization performance. ORP uses NPS to assess customer satisfaction across our operating affiliates.

In short, a headlong rush to more P4P measures in Long-Term Care, without a firm foundation as to their reliability or correlation with quality, might be premature and could lead to results that defeat the underlying goal of quality improvement. In the meantime, progress can be made toward surveys that accurately measure member satisfaction.

Domain 3: Person-Centered Care and Member Experience

Recommendation #3: There Should Be Alignment Between the Medicaid Managed Care Quality Strategy, under DMS, and Quality Goals Developed by the Division of Quality Assurance for Long Term Care Settings.

The DHS Division of Quality Assurance (DQA) exercises regulatory oversight over Long-Term Care settings funded by Family Care, as well as by other funding sources. But the Draft is silent on the relationship, if any, between the quality improvement strategy to be overseen by DMS, on the one hand, and quality initiatives, policies and practices that are already in place or being developed by DQA, on the other.

- DQA oversees compliance with the rules for residential settings based on numbers of beds, i.e., DHS Rule 83 for five- to eight-bed Community-Based Residential Facilities, and DHS Rule 88 for smaller Adult Family Homes.
- DQA supervised the preparation of the State Transition Plan which outlines the State's program for complying with the Home and Community-Based Services Rule (HCBS) issued by the federal government. DQA is also responsible for confirming that Wisconsin Long-Term Care settings supported by HCBS waiver funding comply with the Rule. The HCBS Rule speaks to quality outcomes and program setting requirements that sound very similar to those articulated in the Draft: namely, to ensure that members are treated with respect and dignity, that they can exercise choice, and that they can participate fully in community life.
- DQA has encouraged efforts to enhance quality through specific initiatives. The Wisconsin Coalition for Collaborative Excellence in Assisted Living, or WCCEAL, is an initiative developed by trade associations and approved by DHS, which sponsors a comprehensive quality assurance program. Its purpose is to improve the outcomes of individuals living in Wisconsin Assisted Living communities. Providers who enroll in WCCEAL through their trade associations can be certified as adhering to designated quality standards. There have been proposals that MCO reimbursement be tied to the number of Family Care members who live in WCCEAL-approved settings-yet another P4P concept.

For a variety of reasons that do not need to be spelled out here, we do not believe that WCCEAL in its current form offers an appropriate quality improvement platform for providers of services to Family Care members with I/DD. But we do support moving toward a stakeholder consensus on the quality outcomes that *will* govern services for the Family Care members we serve. When multiple MCOs fund services in a single program but apply different expectations around quality, and when MCOs and providers must comply with different initiatives by DHS, cost goes up with no correlation to quality.

The lack of any reference to WCCEAL or to the role of DQA in quality oversight suggests that the Draft is an overlay by DMS on existing initiatives, for services funded by Medicaid Managed Care. It would be helpful to get DMS's perspective on how the various rules, initiatives and pilots will converge to support a unified view of quality in Long-Term Care settings supported by Family Care.

Domain 4: Health Outcomes and Reducing Disparities

Recommendation #4: There Continues to Be a Compelling Case for Legislative Reform that Would Integrate Acute Care and Long-Term Care, at Least for Complex Individuals Served by Medicaid.

The DHS initiative to roll out an integrated approach to Acute Care and Long-Term Services and Supports for Medicaid beneficiaries stalled in the Wisconsin legislature several years ago. The Draft reflects the bifurcated approach we continue to live with today. DMS had no choice but to map out parallel but separate quality improvement road maps throughout the document, for each category of care. We urge DHS to continue to advocate forcefully for a system that allows a payor to look holistically at the cost of serving an individual with disabilities in the community, both for Long-Term Care and Acute Care. At the end of the day, the same group of people will be the beneficiaries of quality improvement efforts launched under "Column A" (Acute Care) and "Column B" (Long-Term Care). Integration of Acute Care and Long-Term Care would offer significant improvements in the quality of life for people with disabilities, at lower cost.

We can cite two discrete subsets of Family Care clients we serve, who would see immediate benefit from an integrated approach. First are those individuals with I/DD who present with high levels of physical and cognitive challenges. Family Care enables these members to live in the community, rather than a more restrictive setting such as an institution or nursing home. This is a positive result and enhances quality of life.

Yet these individuals continue to have chronic lifelong medical needs. Providers must exercise a great deal of care to ensure that individuals who show symptoms are promptly referred for treatment by an acute care provider or at the hospital Emergency Department. For some, visits can be so numerous as to interfere with quality of life for the clients, disrupt staffing, and increase overall cost. But because different payors are responsible for payments for Acute Care and Long-Term Care, no single entity is responsible for looking "over the fence" to examine the total cost of care, and to develop a treatment framework that allows for more frequent onsite preventive care visits.

A second example can be found in the services we provide for Family Care members with Prader-Willi Syndrome (PWS). PWS is a complex genetic, chronic, life-threatening disorder. People with PWS experience a wide variety of medical challenges throughout their lifetime. On average they incur Medicaid costs for medical care of \$40,868 per year, which is 7.7 times the average cost for people without PWS. Those with PWS require ready access to medical professionals who have expertise in this rare disorder. For example, individuals with PWS tend to have lower metabolic body temperature, so what would be a normal temperature for a typical Family Care member, if present in

someone with PWS, could signal a fever caused by an infection. Each aspect of the Triple Aim-health outcomes, patient experience, and cost effectiveness- are all enhanced when providers of long-term care, acute and primary health services share expertise in PWS and collaborate to assure a seamless approach.

We acknowledge that concerns were raised about the plan to launch Integrated Health Agencies when this matter came before the Wisconsin legislature, and that for the moment DHS' hands are tied on this issue. But it should be possible to embark on pilot projects that would involve identifying a subset of the Family Care population and putting some limited initiatives and measurements in place to demonstrate the benefits of integrated care. The Brown County Population Health Collaborative has begun to tackle this issue for Family Care members in the Northeastern part of the State. Other opportunities are out there.

Conclusion

We appreciate DMS' ongoing efforts to enhance the quality of care for the citizens of the State of Wisconsin who can least afford to protect themselves. ORP welcomes the opportunity to participate in further dialogue.

8

Comprised of more than 12,500 physicians, residents and medical students, the Wisconsin Medical Society (Society) is the largest association of medical doctors in Wisconsin. It is our mission to improve the health of the people of Wisconsin by supporting and strengthening physicians' ability to practice high-quality patient care in a changing environment.

The Society is and has always been a committed partner in improving the programs and quality of care provided by Wisconsin's Medicaid programs and welcomes the opportunity to comment on the Department of Health Services' (DHS) Medicaid Managed Care Quality Strategy (Strategy). The Strategy focuses on four categories of quality improvement: access to care and member choice; cost-effectiveness; person-centered care and member experience; and health outcomes and reducing disparities. To achieve the goals contained within these categories, DHS lays out three types of strategies to maintain and improve the quality of care for Wisconsin's Medicaid members: payment levers, delivery system and person-centered care approaches, and member engagement and choice initiatives.

The Society wishes to offer comments on the Strategy's structure and goals, specifically as it relates to value-based payment, efficiencies in care delivery, patient outcomes and physician satisfaction. The Society hopes that DHS finds these comments useful to help it improve its Quality Strategy and the quality of care provided to Wisconsin Medicaid members.

Value-Based Payment

The Society has long been a supporter of value-based payment provided that such payment structures do not place undue burdens on physicians and patients. As value-based payments become more common, the utility of value-based payments has been demonstrated to improve outcomes in certain applications and settings.¹ However, the key factor to the success of any value-based payment program lies with the design of the program itself.²

The effectiveness of pay-for-performance (P4P) in Medicaid settings has proven effective, albeit modestly.^{3, 4} On the other hand, evidence in some settings has shown that it does not necessarily help reduce health care disparities,⁵ and P4P may actually create perverse incentives for performance in nursing home settings.⁶ Further, relying on patient satisfaction as a metric of quality is not wholly reliable.⁷

In constructing an effective Strategy, the Society suggests that DHS use evidence-based and robust metrics to determine quality. The Society agrees that the well-being and satisfaction of the patient are primary concerns. However, DHS should conduct a thorough review of evidence-based metrics to compliment any use of patient satisfaction data for its P4P reimbursement. Further, the Society suggests that any and all reporting of data be handled by the administrators of the managed care programs and not the physicians themselves.

Improved Efficiencies of Care

The Society holds that the patient-physician relationship is paramount to the effective delivery of high-quality care. Regarding the provision of Medicaid services, the Society supports allocating limited resources to benefit the greatest number of people with comprehensive health care.

With regards to DHS's long-term care Strategy, treating patients in their own homes has proven one of the more effective methods of delivering care.^{8, 9} The Society has long recognized the concept of home health care for long-term care patients as a viable mode of health care for decades. Home health services are most effective when they are tailored to the needs of the individual patient and family. Such services are planned, coordinated, and made available through the use of employed staff, interdisciplinary providers, contractual arrangements, or a combination thereof, and have proven to improve outcomes. Home health services should be made available based upon patient care needs as determined by an objective patient assessment.

Home health services should be provided under the direction and plan of care (developed prior to discharge for those who are to return home from a hospital or nursing home) as outlined by the patient's physician and may include, but are not limited to: appropriate service components such as medical, dental, nursing, social work, home hospice, pharmacy, laboratory, physical therapy, occupational therapy, speech therapy, dietetics, homemaker-home health aide service, transportation, chore services and provision of medical equipment and supplies. DHS and its Strategy should focus efforts on decreasing hospital utilization, which can be achieved without reduction in the quality of care. Failure to provide adequate home care services will result in a potential increase in the burden of illness suffered by the frail and disabled.

The Society acknowledges that while home health care is an expanding and competitive service area, the professional and ethical responsibility, at all levels, is to place the welfare of the patient before personal gain. All home health participants should be alert to and take an active stance against the misuse of patient trust, unnecessary or monetarily inflated services and/or unethical practices. To help

further efficiencies of both home health and long-term care services, the Society urges DHS to discourage over- and underutilization of services. This can be best accomplished for each patient by creating an objective assessment by the physician and home health care service provider for the patient's needs. The treatment plan should include an estimate of the period of treatment, the type of outcome to expect at the end of the treatment period, and the anticipated cost of services.

Patient Outcomes

In developing the Strategy, DHS should maintain its high standard of care for Wisconsin's Medicaid patients.¹⁰ This is what distinguishes Wisconsin's health care infrastructure from many of its peers.¹¹ Any and all structures of the Strategy should keep the health and well-being of the Medicaid population as its primary concern.

Physician Satisfaction

Throughout the Strategy, DHS makes repeated mention of the "Triple Aim" of health care, which seeks to improve overall population health, lower per capita costs and improve patient experience.¹² The Society agrees with these aims, but wants DHS to consider pursuing the "Quadruple Aim," which incorporates physician satisfaction as a core component of overall healthcare infrastructure.¹³ Physicians are experiencing high levels of burnout and dissatisfaction with their careers.¹⁴ This issue is becoming increasingly important as physicians are often asked to take on more and more responsibility for the coordination and administration of health care services. Such burdens compound an already over-loaded profession and can lead to errors in care and reduced outcomes.¹⁵

In constructing the Strategy, the Society urges DHS to help minimize the burden on physicians. Wisconsin Medicaid has some of the lowest reimbursement rates for services such as nursing homes, ¹⁶ primary care,¹⁷ obstetrics,¹⁸ and emergency services.¹⁹ However, as mentioned earlier, Wisconsin has some of the best outcomes for Medicaid nationwide. Creating new requirements or mandates for Wisconsin's physicians is no way to reward them the high level of care they provide. Any new Strategy should take these factors into consideration and minimize or eliminate the reporting requirements for physicians. This will help to maintain the high level of care we have come to expect, and help Wisconsin's physicians to keep treating Medicaid patients and their families.

The Society thanks DHS for the opportunity to comment on its Strategy, and looks forward to continuing being a partner in improving Medicaid for all Wisconsin residents.

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9 The Wisconsin Medicaid Managed Care Quality Strategy meets the federal requirements of 42 C.F.R. § 438.204 to describe the strategies for assessment and quality improvement of managed care services offered to Medicaid beneficiaries. It includes the specific strategies Wisconsin will use to align programs to best meet the health care needs of Medicaid members and continually improve health for Wisconsin residents. The Quality Strategy sets a three-year vision for the Division of Medicaid Services to achieve its quality goals and objectives and is intended to evolve over time. The Quality Strategy includes BadgerCare Plus and SSI HMOs, Health Homes, Family Care, and Family Care Partnership programs.

Overall Care Wisconsin agrees with the goals and objectives described in the Wisconsin Medicaid Managed Care Quality Strategy. Comments are intended to raise points for further discussion prior to finalizing the strategy. The following comments are separated by Acute Care vs. Long-Term Care.

Acute Care:

Section 3d Organizational Goals, Objectives, and Foundational Principles-- DMS Quality Goals and Objectives: § 438.340(b)(2) [Page 17](#)

Goal 3: Improve engagement of BadgerCare Plus and SSI HMO members in their care and experience of care.

Objective:

Increase engagement of BadgerCare Plus and SSI HMO members in self-care, and increase provider-delivered care that is culturally competent for BadgerCare Plus and SSI HMO members.

Further definition of self-care in SSI would help put this objective into context. It is not clear if this is a general term referring to their health or specific to functional characteristics. We suggest this be changed to: *"Increase engagement of BadgerCare Plus and SSI HMO members in their care, and increase provider-delivered care that is culturally competent for BadgerCare Plus and SSI HMO members."*

Long-Term Care:

Section 3d Organizational Goals, Objectives, and Foundational Principles-- DMS Quality Goals and Objectives: § 438.340(b)(2) [Page 16](#)

Goal 1: Empower Family Care and Family Care Partnership members with access to an array of services and supports.

Objectives:

- Reduce the length of stay of Family Care and Family Care Partnership members in institutions for mental disease after the member is determined psychiatrically stable.

Care Wisconsin agrees that this is a good goal. However, stable in an institution is different than stable in the community. For example, members w/ IV Haldol or certain behavioral interventions may be considered psychiatrically stable in an IMD, yet techniques and interventions that may be used in an institutional setting do not always transfer to community settings. We suggest that this be changed to: *“Reduce length of stay of Family Care and Family Care Partnership members in institutions for mental disease after the members have been determined to be psychiatrically stable and their needs can be met safely in a residential and/or independent living (with supports) setting.”*.

- Offer a wider range of relevant data to Family Care and Family Care Partnership consumers (for example: member satisfaction survey results, pay-for- performance results, interdisciplinary teams, staffing ratios and turnover, information about sanctions). Care Wisconsin has concerns regarding the generalizability of data points so that consumers have apples-to-apples comparisons. For example, Family Care and Family Care Partnership are very different programs and satisfaction rates should not be presented as comparable. Also, the target group percentages are different across programs (ex: MyChoice Family Care is mostly FE and Care Wisconsin Family Care is majority ID/DD). Data and information shared with potential members should always be presented in context so that the public is not misled. Careful consideration should be given to data prior to approval for public reporting.

Goal 2: Promote efficient and cost-effective services and supports in Family Care and Family Care Partnership through innovation, standards, data-driven quality, and evidence- based practices.

Objectives:

- Increase the number of pay-for- performance measures included in each long-term care MCO contract. Care Wisconsin recommends a process similar to CMS Advance Notice Call Letter that outlines what is coming up in the measurement year so that there is time to prepare. This Call Letter should have all of the P4P measures in it and allow for a comment period similar to the CMS Advance Notice. This way MCO’s can weigh in on potential problems as well as begin the process of building the infrastructure to support the tracking and monitoring. Due to the data being publicly reported and also tied to revenue, this is essential.

In addition, we recommend Quality calls similar to SSI/Badgercare where all plans can choose to have a representative on the line to give input on measurement and changes to the process.

Goal 3: Focus on the whole person in Family Care and Family Care Partnership, including physical, psychosocial, and spiritual needs to live and work freely in the home and community. [Page 17](#)

Objectives:

- Increase the percentage of Family Care and Family Care Partnership members who live in a private residence (i.e., home, family home, apartment).
- Increase the rate of competitive integrated employment of Family Care and Family Care Partnership members who want to work.

Care Wisconsin would like to point out that the two objectives for the goal are not a full measure of the goal. We recommend that this goal be changed to omit the physical, psychosocial, and spiritual needs so that it is as follows:

Goal: Focus on the whole person in Family Care and Family Care Partnership, including working in the home and community.

Additionally, Care Wisconsin requests more information on the definition of the term “integrated employment” before it is released to the public as a performance measure.

Goal 4: Engage Family Care and Family Care Partnership members to make meaningful choices about where and with whom they live, and their services and who provides them. [Page 18](#)

- Increase the percentage of Family Care and Family Care Partnership members who self-direct at least one service in their care plan.
The SDS philosophy is that everyone can self-direct, but some people may have health and safety risks that in certain instances preclude the safe use of SDS. Care Wisconsin would like to make sure that the members that are included in the denominator for this measure are appropriate for SDS so that there is not an incentive to have a member self-direct regardless if it puts the member’s health and safety at risk.

Additionally, before this measure is made public, we request more definition as to what counts as SDS (ex: does a member overseeing their own lease count as SDS? Or does having a homecare worker hired through Community Living Alliance count as SDS?). We also recommend exclusions such as members who are in bundled residential settings.

- Increase the percentage of service plans that address the assessed needs and personal goals of Family Care and Family Care Partnership members.

Care Wisconsin requests more definition of how this will be measured prior to public reporting. Care Wisconsin has concerns that the current methodology used in the Metastar CMR tool is not a true reflection of the quality of a care plan. We recommend that

further discussion of this measure occur before it is used as Pay for Performance or publicly reported.

- Additionally, based on recent experience with contract changes that impacted AQR scores, Care Wisconsin requests that any contract changes that will impact the publicly reported and P4P scores be specifically communicated one year prior so that MCO's have time to properly implement the changes (see also recommendation above for a Call Letter and Quality conference calls with MCO's).

Member Engagement and Choice Strategies

Long-Term Care Choice Strategy [Page 24](#)

Empowering members to choose their long-term care MCO based on relevant, user-friendly, and transparently reported information is a DMS priority. The types of information provided to members will include member satisfaction scores for each long-term care MCO, pay-for-performance results, the number of members who report living in their setting of preference, the number of members who self-direct services, MCO-specific interdisciplinary care team staffing and turnover ratios, and information about sanctions, noncompliance, and National Core Indicators

As stated above, Care Wisconsin has concerns regarding the generalizability of data points so that consumers have apples-to-apples comparisons. For example, Family Care and Family Care Partnership are very different programs and satisfaction rates should not be presented as comparable. Also, the target group percentages are different across programs (ex: MyChoice Family Care is mostly FE and Care Wisconsin Family Care is majority ID/DD). Data and information shared with potential members should always be presented in context so that the public is not misled. Careful consideration should be given to data prior to approving for public reporting.

Care Wisconsin would like to see the reference to use of numbers of members removed and replaced with percentages or rates. Comparing MCO's by using numbers will not be useful to potential members given that the census numbers vary widely by MCO.

10 WAFCA appreciates the opportunity to comment the draft *Medicaid Managed Care Quality Strategy*.

WAFCA is a statewide association that represents over fifty child and family serving agencies and leaders in the field and advocates for the more than 250,000 individuals and families that they serve each year. Our members' services include family, group and individual counseling; community-based care, Family Care, substance use treatment; crisis intervention; outpatient mental health therapy; and foster care programs, among others.

We appreciate this document's emphasis on quality care, patient access and engagement, value-based payment and improved health outcomes.

1. **Reduced lengths of stay.** Goals for reduced lengths of stay need to be structured in ways that avoid premature discharge of enrollees resulting in undesirable health/mental health consequences.

2. **Customer satisfaction surveys.** While customer satisfaction is significant and definitely important to measure, given all the shortcomings of achieving solid satisfaction survey results, making customer satisfaction a sole measure of performance would be questionable.
3. **Incentive and disincentive performance payments.** – Wisconsin Medicaid rarely pays all costs of care. To take dollars away from an organization that is performing below the desired standard will make it much less likely that the organization will reach the desired performance level. If it is believed that market forces will not remove poor performers, then standards should be developed for the removal of poor performers from the program rather than reducing payments. Incentive payments should be the strategy for improving performance and encouraging good performers to increase their market share.
4. **Uniform quality standards.** One set of quality standards should be developed for all MCOs. If each MCO has different standards, administrative costs for provider agencies will increase – likely quite significantly – with no positive affect on quality of care.
5. **Stakeholder input.** Provider and consumer input should be required in the development of all performance and payment standards at both the Medicaid program and the managed care organization levels. Input from these groups will result in more thoughtful, achievable and productive standards that will lead to better health outcomes and a stronger managed care program.

WAFCA member, Oconomowoc Residential Programs, which includes Genesee Lake School a nationally accredited organization, is also submitting comments that we hope you will consider carefully. Their extensive experience with Medicaid managed care organizations serving individuals with disabilities informs their thoughtful comments that warrant your careful consideration.

We do appreciate the opportunity to comment on this draft and are ready to work with you on subsequent drafts and the development of managed care standards.

11 The Wisconsin Association of Health Plans appreciates the opportunity to review the Department of Health Services’ (DHS) draft Medicaid Managed Care Quality Strategy. Wisconsin’s community-based health plans are committed to providing access to quality health care to members of the BadgerCare Plus, SSI, Family Care, and Family Care Partnership programs.

As DHS finalizes the Quality Strategy and administers various quality programs, community-based health plans encourage the Department to consider and leverage the unique characteristics of local and integrated plans. To further advance the Department’s goal of improving health outcomes for members, community-based health plans also encourage DHS to explore policy and payment opportunities to help health plans address the social determinants of health.

In addition, health plans appreciate the efforts DHS described in the draft Quality Strategy to reduce duplicative quality reporting and review. To promote additional efficiency and accountability, health plans encourage DHS to consider looking broadly across state-funded programs – including those administered by the Department of Employee Trust Funds – to align quality expectations and quality reporting measures for health plans.

Wisconsin’s community-based health plans look forward to working collaboratively with DHS to continue providing high quality health care to members of DHS programs.

12

The Wisconsin Primary Health Care Association (WPHCA) is pleased to be given the opportunity to respond to the Wisconsin Department of Health Services (DHS) “Medicaid Managed Care Quality Strategy.”

WPHCA is the member organization of Wisconsin’s eighteen Community Health Centers designated as Federally Qualified Health Centers (FQHCs). Wisconsin Health Centers play an integral role in providing comprehensive primary medical, dental and behavioral health care for individuals in some of the most underserved communities in our state, and represent a valuable source of health care for Wisconsin’s Medicaid population, which provides insurance coverage for 62 % of Health Center patients.

Wisconsin Health Centers are working towards many of the quality goals identified by the Department, including improving access to care and health equity, providing patient-centric, high-quality, and cost-effective care. As the majority of Health Center patients are BadgerCare Plus beneficiaries, we applaud the Department’s work in promoting a more robust quality strategy to better assess and improve managed care services for our patients. Moving forward, we hope the process continues to be transparent and brings together both providers and managed care organizations to better align strategies with the quality improvement work currently happening in Health Centers and by other providers.

WPHCA appreciates DHS' effort and collaboration in drafting this plan, and the opportunity to comment on the “Medicaid Managed Care Quality Strategy.” Our comments are organized by the structure of the draft plan presented by DHS, and focus primarily on the goals and strategy around acute Medicaid services through the BadgerCare Plus program.

Wisconsin Primary Health Care Association

Section 4: DMS Quality Strategies

(a) Payment Strategies: The following comments and recommendations focus on the Department’s proposal to promote payment strategies to enhance quality that include pay-for-performance, alternative payment models, and strategies that reduce avoidable, non-value added care.

Comments

- WPHCA appreciates the continued focus on pay-for-performance initiatives and alternative payment models outlined in the department’s strategy
- Alignment with the Quality Payment Program (QPP) is of concern for Health Centers, as the majority of Health Centers are not required to submit data under this program and are unlikely to be aligned with the current standards. Currently, Health Centers are aligned with the Medicaid EHR Incentive Program, often referred to as Meaningful Use (MU), and report quality data through

that program rather than the QPP. In terms of QPP reporting, the majority of Health Centers do not exceed patient and dollar minimums that require providers and organizations to submit data under the QPP. While some are part of Advanced APMs (Alternative payment models), under the QPP, there would not be a requirement to submit quality data, as APM participants report at the aggregate level for quality, and only at the provider or organization level for the ACI (Advancing Care Information) category. However, there remains some overlap in the quality measures under the QPP with the quality measures that are part of the Medicaid EHR Incentive Program and the HRSA Uniform Data Reporting System's CQMs. These measures would be preferred for Health Centers, and WPHCA would be able to provide these detailed measures if needed.

- In regard to reducing avoidable care, there are current challenges for Health Centers to divert patients from utilizing the Emergency Department rather than receiving care in the appropriate outpatient setting. Receiving information from hospitals or MCOs on when Health Center patients access the ED, or are admitted to the hospital, would allow Health Centers to follow up with patients and schedule follow-up appointments, and encourage appropriate utilization of services.
- If Medicaid wants Health Centers to become PCPs for patients in need, there needs to be more communication between MCOs and providers to ensure that assigned providers have the capacity to increase their panel size.

Recommendations

- Provide flexible pathways for Health Centers to meet the value metrics that DHS has laid out for MCOs.
- WPHCA would appreciate the Department working with providers, including Health Centers, when finalizing QPP measures for MCOs to foster alignment across providers and payers in terms of quality measures.
- We recommend that the department foster a better partnership or direct EHR connections between Health Centers, hospitals, and MCOs in order for Health Centers to have access to data identifying when a Health Center patient is visiting the Emergency Department or admitted to the hospital. WISHIN is potentially the best solution in terms of this information and requiring (or encouraging) all hospitals and EDs to send health information to WISHIN would give Health Centers needed health and utilization information on their patients, allowing for better population management by providers.
- In addition, allowing for incentives – either through Medicaid or through the MCOs—for Health Center involvement in efforts to reduce avoidable care. Potential areas for incentives could include incentives for Health Centers that reduce ED visit volume on a quarterly basis, and reimbursable care coordination time, which would allow Health Centers to dedicate staff to population management.

(b) Delivery System and Person-Centered Strategies: The following comments and recommendations are primarily regarding the Department's strategies around enhancing care coordination and person-centered care, improving health homes, and ensuring health and safety of members.

Comments

- WPHCA appreciates the Department's focus on enhancing care coordination and person-centered care. Care coordination and person-centered care is central to the Health Center model of care. However, there needs to be both reimbursement for these

services as well as more clarity regarding pathways for Health Center reimbursement for these services.

Recommendations

- Reimbursement for Health Centers through MCOs for a number of services that Health Centers engage in as part of their practice model to enhance care coordination and Person-Centered care. These include:
 - 1) Care Coordination
 - 2) Care Management
 - 3) Social Determinants of Health Screening
 - 4) Non-Medical services (e.g. transportation, housing assistance) that increase patient health
- Reimbursement through these alternate strategies should have defined pathways either as a pass through from MCOs or preferably through direct reimbursement to Health Centers from DHS.
- Implement financial incentives for achieving Patient Centered Medical Home (PCMH). This would help Health Centers work with the state and MCOs to meet the quality goals outlined within this strategy – particularly those around health home improvement.
- WPHCA would encourage the department to allow for more medical home initiatives based on special populations, including: individuals with Serious Mental Illness and Substance Use Disorders, sickle cell patients, and women of child bearing age who are at risk for high-risk pregnancies.

(c) Member Engagement and Choice Strategies: The following comments and recommendations are in regard to the proposed strategies promoting member engagement through a variety of educational and technology related strategies.

Comments

- In general, WPHCA is concerned with the plan for beneficiaries to utilize online HMO portals. Currently, Health Center providers and staff find it challenging to engage their patients in using existing patient portals.
- In some markets, Health Centers may need to access several different portals to obtain member assignment lists. Additionally, HMO provider facing portals could be used by Health Centers to update and reconcile PCP assignments. This would save Health Center staff time as the current process requires a time consuming three-way phone call between Health Center staff, HMO staff and the member/patient.
- Currently there are obstacles in terms of reconciling member plan assignments. A MCO member may be actively engaged with a Health Center but assigned to another PCP not at the Health Center.
- For better patient self-engagement in care, the state and MCOs need to make the process of changing a PCP much less cumbersome.
- Health Centers have consistently reported that MCOs, responsible for providing interpreters for medical appointments, frequently do not provide them.
- WPHCA would like to see more details regarding the cultural competency strategies. For example: will it be easier for patients to

have calls/get paperwork/use the portal in their native language?

Recommendations

- Health Centers and their providers should be given read-write access to payer portals to allow for information to be updated in real time, including PCP and any health information.
- We do not recommend patient/member portal access, given the low utilization of EHR portals by Health Center patients.
- The state should develop a more streamlined process where a patient and/or a provider can update PCP assignments in a more streamlined (electronic) format rather than via 3-way phone call, which seems to be the current standard today. One solution may be for the state to partner with WISHIN and mandate that Medicaid HMO share provider assignments with providers of care through WISHIN.
- The State should develop more accessible information on MCO quality and improvement that is up-to-date and accessible to patients.
- WPHCA recommends that the state do quality-based, competitive contracting with MCOs.
- The state and MCOs should provide better clarity for both patients and providers so providers know if recommended services (including non-medical services like acupuncture, chiropractic care and massage services) or referrals are covered by the patient’s insurance
- These should be available both in the member handbook and through other online resources.

5. Enabling Infrastructure: Data and Technology

(a) Accelerate Quality Monitoring: Our comments and recommendations in the section focus on DMS strategies to accelerating work around and establish an electronic quality measurement system.

Comments

- The state, MCOs, and providers have many disparate systems and requirements today. It would be most helpful to create an integrated, aggregated data base of all disparate sources, and allow providers to tap into that single source of integrated data.

Recommendations

- The State should fully leverage WISHIN, and incentivize use of WISHIN through data submission and contract requirements for payer/provider utilization of the network.

(b) Use Technology to Engage Members: The following comments and recommendations focus on the Department’s plans to use HIT to help HMOs and MCOs share information with members about their health status and delivery and quality of care, including greater use of telehealth, remote patient monitoring, member education, and other patient engagement tools.

Comments

- Patient portals should not be duplicated. Health Centers currently have challenges engaging patients to use portals, and we

caution DMS to temper expectations for member engagement, particularly in the absence of a specific, tangible benefit to using it.

- Increasing the use of telehealth and teleconsultation are important in improving access to care – especially for behavioral health.

Recommendations

- If HMO portals include a member/patient facing aspect, please consider the following:
 - Ensure that HMO patient portals integrate into existing patient portals used by Health Center patients.
 - Ensure that portal content is available in multiple languages and optimized for use via mobile devices.
 - Ensure content is both useful for members/patients and presented in a manner that is easily understandable.
- Require reimbursement for telehealth services at the PPS rate for FQHCs.

6. DMS Managed Care Programs

a. Acute Care Programs: The following comments and recommendations focus primarily on the department’s work on health homes and medical homes.

Comments

- In terms of health and medical homes, allowing for enhanced reimbursement for population specific health homes is beneficial.
- We believe that since insurers do not provide direct patient care and clinical services they have limited ability in improving quality engagement and satisfaction of members. Providers, at the point of care, have the best opportunity to improve the overall measures.

Recommendations

- Research has demonstrated that Primary Care Medical Homes with robust health and social care coordination capabilities have demonstrated the best outcomes—reinforcing the need for a strategy of embedding care coordination within the actual health home. Reimbursement for care coordination, and incentive payments for achieving PCMH status, would allow Health Centers to better focus their work and staff on these activities.

7. Quality Assurance

a. Access Standards: The comments and recommendations in this section focus on the Department’s recommendations regarding access standards through network adequacy and service standards

Comments

- Currently MCOs do not adequately monitor open or closed panels in the course of a contract due to the current manner in which the state operationally defines network adequacy. The current definition allows MCOs to claim providers in their network that may be claimed by other MCOs, and MCOs are able to claim providers regardless of assigned patient volume.
- The MCO urgent care network requirement definition is also vague with no standard measurement for urgent care adequacy.

Recommendations

- Network adequacy standards should be reflective of a provider's actual capacity to take on new patients and have some consideration of patient volume. MCOs voluntarily report if a provider is closed or no longer providing care. Some kind of monitoring in the course of the term of a contract would be beneficial. Currently, the only time network adequacy is monitored through the ombudsman compliant process.
- Network adequacy standards should include primary care, urgent care and specialty care in addition to behavioral health and dental.

b. Service Standards: The comments and recommendations in this section focus on the Department's objectives and goals around evidence based clinical practice guidelines, members with special needs, transitions of care policy, and health disparities.

Comments

- In terms of evidence-based clinical practice guidelines, we would like to see more about how the Department will work with MCOs to address health disparities, and how they will implement any strategies to measure changes in health disparities.
- We would like to additional information from the Department about the clinical practice guidelines that are part of this year's SSI contract. MCOs are not clinical practice providers - how can they enforce these standards?
- In terms of transitions of care policy, we would like more details to see how continuity of care is achieved.
- The current strategy/plan around health disparities is very vague. It is not clear what data will be used and whether the data collection process might be repetitive since some clinics are already collecting Social Determinants of Health data as part of their clinical practice.

Recommendations

- In terms of health disparities, we recommend that the department provide more clarity and identify more specific areas of disparity in order to promote more robust engagement from payers and providers around strategies to reduce health disparities.

8. Roadmaps

Comments and recommendations for this section focus on the priority activities outlined by DHS.

Comments

- WPHCA would like to see PCMH being recognized as a "health home" mode, and encourages DHS to consider providing funding for those achieving PCMH status.
- We would also like the Department to explore opportunities to use Medicaid dollars for non-health needs (social needs) after the data on Social Determinants of Health (SDOH) is collected and disparities are apparent. For example, in Illinois there was a pilot where hospitals and payers paid for rent for high-utilizing Emergency Department patients experiencing homelessness. They saved millions of dollars over the course of a few years. WPHCA would be interested in engaging with the department on similar

opportunities once the data becomes available.

13 Introduction

Disability Rights Wisconsin (DRW) is the Protection and Advocacy system for people with disabilities in Wisconsin. DRW represents thousands of low-income Wisconsinites every year, including some of Wisconsin's most vulnerable children, seniors, families, victims of crime, and survivors of violence.

We found the Wisconsin Department of Health Services' Medicaid Managed Care Quality Strategy to be broad and unspecific regarding what measures will be put in place and how they will be carried out. The specific data collection methodologies are not listed. Thus, it is difficult to discern what DHS's vision for quality measurement is. The document (p. 9) states that it "meets the federal requirements of 42 C.F.R § 438.204 (2013)." That regulation no longer exists. We assume the correct citation is 42 C.F.R § 438.340 (2016). Assuming that to be the case, the document falls far short of that regulation's mandatory requirements for what needs to be included in Wisconsin's managed care quality strategy. **Our initial recommendation is that DHS withdraw this document and prepare one that complies with the mandates of 42 C.F.R § 438.340 (2016). That revised strategy document should then be released for a new public comment period.** We offer the following specific comments on how managed care delivery quality may be improved.

Stakeholder Input Must be Incorporated into the Strategy

Absent from this proposal is how stakeholders will be involved in decision-making to ensure quality processes and results. The people receiving these services are in the best position to determine if they are having a quality experience. Their involvement in what should be measured and how it should be measured is critical.

Ombudsman Programs as a Quality Check Resource

Wisconsin's statutes require that DHS contract with an advocate for people aged 18-59 in the managed long-term care system (Wis. Stat. § 46.281(1n)(e)). DHS contracts with DRW to operate this program. The Board on Aging and Long-Term Care, which is the state's long-term care ombudsman, assists managed long-term care enrollees who are over the age of 59. A similar DRW program, the SSI Managed Care External Advocate Program (SSIMCEAP) serves the SSI members enrolled in HMOs. The fact that these ombudsman/advocacy programs exist is testament to the state's desire to ensure enrollees and potential enrollees have help when they encounter challenges in managed care programs. In the process of conducting their individual casework, the ombudsman/advocacy programs identify trends of concern across the state or in a particular managed care organization. They are also tuned into due process issues that enrollees might be experiencing. Through quarterly meetings and other regular contacts, the ombudsman programs traditionally shared these trends or concerns with DHS so that DHS could address them. In this way, DHS was able to problem solve issues in their early stages, before there were severe impacts on many enrollees. In addition, ombudsman programs sometimes alert DHS oversight staff to individual member issues that need intervention by DHS to correct improper MCO actions. Because the ombudsman/advocacy programs provide a valuable "on-the-ground" quality check, we are surprised to see no mention of them in the entire plan. **We recommend that consultation with the ombudsman /advocacy programs be added throughout the Quality Strategy as an important quality check.**

Strengthening DHS Oversight

DHS has had key management and oversight positions remain open and unfilled for a very long time. This can only result in an easing of what used to be reasonably tight oversight of managed care organization activities. We asked the ombudsman program at DRW for impressions of the oversight provided by DHS staff who are assigned to MCOs. They noted a diminution in the desire to hold MCOs accountable to meet member needs. The ombudsman program observed that oversight staff seem less inclined to intervene on behalf of members. This may be because of the assignment of specific “member care quality specialists” (MCQS) to specific MCOs. While the system allows the MCQS to become familiar with the operation and personnel of the particular MCO, that familiarity has, in some cases, led to the MCQS identifying too closely with the interests of the MCO to which they have been assigned. A better system might be to have a pool of MCQSs who are assigned to member complaints as they come in, regardless of the MCO involved.

Pay for Performance (PFP)

PFP strategies can be effective when paired with incentivizing strategies. However, DHS’s Quality Strategy seems to have evolved into the more punitive side of enhancing performance (with its emphasis on “withholds,” “potential sanctions,” and “penalties”) as evidenced by the fact that only PFP is mentioned. Rewarding managed care organizations for investing in innovative strategies to hone in on and address member needs should be incentivized. For example, finding solutions to housing, opening up access to the community, or taking significant steps toward increasing cultural competence and connection through creative program development should be rewarded.

We are also concerned about the limited data upon which PFP will be determined. As stated on page 20 of the Quality Strategy, PFP will be tied to member satisfaction surveys. In order to rely on surveys only, a solid survey process will need to be put in place to obtain valid results. The use of only a PFP element without incentives places a significant burden on well-done surveying in order to prevent erroneous sanctions. It was unclear what safeguards will be put in place to avoid this occurrence.

National Core Indicators

We are pleased that the state has partnered with the Human Services Research Institute (HSRI) to participate in National Core Indicators (NCI) to collect quality data and compare it to other states. This is a well-regarded, reliable system that has collected valuable data across the country for many years. Implementing this program in Wisconsin has been quite an undertaking; we are eager for the results and commend DHS for this initiative.

Regional Long-Term Care Advisory Committees

In creating Family Care, Wisconsin statutes added a requirement that DHS develop Regional Long-Term Care Advisory Committees (RLTCACs) (Wis. Stat. § 46.2825). This was in part to remedy the fact that when a county rolled over to managed care, opportunities for people who receive services had no avenue to positively influence the provision of services or the policies that impacted them on a local level. Though improvements could certainly be made to the statute, the beauty of it is that it provides the only way to really examine how

things are going in one's area, both positively and negatively, and it provides a path to make recommendations for improvements. It encourages a cooperative exchange between MCOs and the people affected by local access to services. In addition, the RLTCACs would be particularly useful in identifying, and gathering information about specific workforce inadequacies in their regions.

Yet these committees were never implemented. There has been a confounding resistance to doing so. In 2010 and 2011 ineffectual efforts to collect local comments were made, but the processes and results were quite disconnected from the requirements of the statute. No actual implementation that adheres to the statute has ever taken place. This would be a prime opportunity to understand the quality and sufficiency of services in an area, and RLTCACs would provide recommendations for improvement. This would be done through data sharing (types of services supported, disenrollment data, etc.) required of MCOs and ADRCs and through local understanding of gaps in services.

We recommend that DHS take immediate steps to implement the RLTCAC statute as a demonstration of commitment to the value of quality assurance. We have included the statutory language in the appendix to clearly illustrate its forward-thinking goals. We encourage serious consideration of how RLTCAC might be implemented across the state.

Monitoring of Trends Over Time

There do not appear to be systems in place to monitor the impacts of managed care change implementation or changes in policy or practice. Here are a few examples.

Workforce capacity: It is widely understood that Wisconsin, like many other states, is facing a significant workforce shortage. As provider rates are driven sharply down, while "scope of services" included in contracts with providers have increased (in other words providers are expected to do more with less), it is impossible to divorce the obvious impact managed care must have on the workforce. Financial challenges faced by providers further exacerbate the reduction of resources they have available to attract quality staff. Nothing is mentioned in the Quality Strategy about how DHS has or will track these very serious issues. To DHS's credit, an ongoing discussion is occurring with stakeholders to find solutions, but those solutions never seem to address the pay/contract issues faced by providers. Though discussions are happening, it appears that no data collection on provider impact has occurred over time, hampering the ability to make decisions based on data analysis. In order to truly understand whether quality service is being provided at an appropriate cost, DHS needs to gather the data necessary to establish whether the rates MCOs are paying providers are, in fact, adequate to ensure that the consumers desired outcomes are being met. If DHS determines that the MCO provider rates are inadequate it then needs to determine if the capitated rate it pays the MCOs is adequate. Significant data collection is needed.

Changes in policy: In 2013, a significant change was made to the tool used by managed care organizations to make decisions about services that will be included in a member's person-centered plan. This tool is called a RAD (Resource Allocation Decision), and it walks a care team through a short series of questions that define the problem, consider options, and finally helps the team

determine the best support that will serve the intended goal. The original RAD focused on “personal experience outcomes,” which focused on what the member’s goals were, and the RAD questions were very member centered, allowing the member to express preferences and dialog about options. The revised RAD is focused on “long term care outcomes,” which can be identified by the member OR the care team staff, and must meet “clinical or functional needs.” Member preference has been removed from the tool. This change in focus from person-centered to MCO-centered decision making must have had a significant impact on the development of care plans. As far as we could see, no data tracking was done. We asked the ombudsman program at DRW if they saw a change at the time of the change to the RAD and if they see an ongoing impact. They were able to anecdotally report that they saw a shift away from supports for community integration toward a narrowing emphasis that focused on ensuring health and safety. Without data tracked by DHS, it is impossible to objectively evaluate changes like these.

Changes in practice/protocol: In the beginning of 2017, DHS implemented a change to the target group determination in its Long-Term Care Functional Screen (LTCFS). This change not only automated the process to improve consistency (the stated goal of the project), but also changed the actual determination factors. This primarily affected individuals with intellectual and developmental disabilities, and it caused a significant increase in the number of people finding themselves ineligible for the full benefit package. At the time of implementation and for months afterward, DRW requested the impact numbers many times. It finally took a FOIA request to obtain them. It was hard to know if DHS was tracking the impact before and during the implementation of this significant change, or if the FOIA request caused officials to pull the data. Tracking numbers before and during implementation of new projects would allow DHS, ombudsmen, advocates, providers, and others to respond in a way that minimizes negative impacts.

Appeals and grievances: It would be helpful to know what types of appeals and grievances are taking place, along with the results. 42 C.F.R. § 438.416 mandates states to require PIHPs to “maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.” We see no reference to using data derived from this monitoring in the plan, though this was to be effective 7/5/16.

Use of Stakeholder Input

DHS has access to numerous avenues to obtain stakeholder input. Regarding policy development, DHS tends to use its’ relationship with these individuals and groups as a reporting function, rather than an opportunity to receive meaningful feedback. Though DHS has continuing communication with community advocates, it seems averse to involving them while developing policies or making changes. Stakeholders can provide valuable ideas and suggestions to the development of policies and programs that will increase quality and will often avoid unnecessary problems or hardship on members. Here are a few examples.

Changes to the Long-Term Care Functional Screen: As noted above, the LTCFS was changed at the beginning of 2017. As far as DRW can discern, changes to the LTCFS (automation of target group determination) were made without input from anyone outside of DHS. The reported purpose was to create consistency in how screeners entered information. The actual outcome was a

substantive change in target group determination factors. Because the changes were made in a vacuum, no one had an opportunity to avoid the negative impact on many enrollees and potential enrollees.

Annual changes and updates to the MCO contract: Wisconsin uses a “generic” contract; all MCOs abide by the same contract. It is updated at least annually to reflect changes in federal or state requirements or changes in program policy set by DHS. In one notable instance, DHS worked closely with DRW to rewrite language to better protect vulnerable adults receiving services. After a tragic event that resulted in a member death, DRW investigated the situation and wrote recommendations to DHS that increased in-person contact requirements. DHS was open to the recommendations; the language change to the contract has resulted in improved oversight for well-defined vulnerable or high-risk adults. This situation was a demonstration of a collaborative effort that resulted in an improved product. This was, unfortunately, the exception to the rule. DHS makes sometimes small and sometimes significant changes to the contract, all without any stakeholder involvement during contract development and editing. We asked the ombudsman program at DRW if they are given an opportunity to provide feedback and we were told that they are not. At the very least, the external Ombudsman programs (DRW’s and BOALTC’s as well as DRW’s SSIMCEAP) should be consulted on changes to the contract as those changes are being considered and developed, not after they have been finalized. Such a dialogue occurs between DHS and the MCOs as annual contract revisions are developed. There is no reason LTC consumers (through their advocates) as the beneficiaries of these contracts, should not be involved in contract change discussions from the time they are initiated. If DHS oversight is easing, as is mentioned above, we are concerned that critical language in the MCO contract might not only lose its strength, but some of it might actually be removed altogether. This should not be done without consultation with at least some stakeholders, such as the ombudsman programs.

Development of Tribal-specific services: It is unclear in the plan what is meant by “tribal consultation.” It seems to be mentioned only in passing without specifics about quality monitoring with or for the Tribes. Have the Tribes been able to provide meaningful input into the quality assurance of managed care for their members? If so, what has been or will be put in place to monitor quality? Will those quality assurances be more than punitive sanctions on Tribes as they work to implement long-term care programs that integrate their members with managed care organizations? Is DHS providing adequate information and support to the Tribes, while respecting the sovereignty of the Nations, so they can successfully implement complicated Medicaid programs and maintain culturally relevant services to their members?

Culturally and racially diverse stakeholders: In a few places, the plan suggests implementation of “culturally and linguistically appropriate services,” but it is unclear how the quality of those services will be measured. It is further unclear how stakeholder input will be sought by various populations to implement quality programs.

Mental health stakeholders: While mental health is addressed throughout the document regarding acute care, it is not clearly addressed for long-term care. There is a brief mention about “providing increased support for behavioral health” on pages 33 and 34. The Quality Strategy should indicate how DHS intends to ensure that LTC enrollees receive appropriate and adequate mental

health treatment and support. There has been a disconnect between Family Care and the coordination with county mental health support systems and other providers. DRW has worked with DHS for many years to address this issue and DHS has taken some steps to improve the managed care response. Mental health advocates should continue to be involved with decision making on these issues. DHS should be closely tracking whether enrollees are adequately accessing mental health services. There is no articulated methodology to do so in the Quality Strategy.

APPENDIX

Regional Long-Term Care Advisory Committees: Wis Stat. § 46.2825

46.2825 Regional long-term care advisory committees.

- (1) CREATION.** The governing board of each resource center operating in a region established by the department under s. 46.281 (1n) (d) 1. shall appoint the number of its members that is specified by the department under s. 46.281 (1n) (d) 2. to a regional long-term care advisory committee. At least 50 percent of the persons a resource center board appoints to a regional long-term care advisory committee shall be older persons or persons with a physical or developmental disability or their family members, guardians, or other advocates.
- (2) DUTIES.** A regional long-term care advisory committee shall do all of the following:
- (a)** Evaluate the performance of care management organizations and entities that operate a program described under s. 46.2805 (1) (a) or (b) in the committee's region with respect to responsiveness to recipients of their services, fostering choices for recipients, and other issues affecting recipients; and make recommendations based on the evaluation to the department and to the care management organizations and entities, as appropriate.
 - (b)** Evaluate the performance of resource centers operating in the committee's region and, as appropriate, make recommendations, concerning their performance to the department and the resource centers.
 - (c)** Monitor grievances and appeals made to care management organizations or entities that operate a program described under s. 46.2805 (1) (a) or (b) within the committee's region.
 - (d)** Review utilization of long-term care services in the committee's region.
 - (e)** Monitor enrollments and disenrollments in care management organizations that provide services in the committee's region.
 - (f)** Using information gathered under s. 46.283 (6) (b) 2. by governing boards of resources centers operating in the committee's region and other available information, identify any gaps in the availability of services, living arrangements, and community resources needed by older persons and persons with physical or developmental disabilities, and develop strategies to build capacity to provide those services, living arrangements, and community resources in the committee's region.
 - (g)** Perform long-range planning on long-term care policy for individuals belonging to the client groups served by the resource center.
 - (h)** Annually report to the department regarding significant achievements and problems relating to the provision of long-term care services in the committee's region.
 - (i)** Review and assess the self-directed services option, as defined in s. 46.2899 (1).

History: 2007 a. 20 ss. 968, 970, 977; 2015 a. 55.

14 The Wisconsin Hospital Association (WHA) and our members are committed to the goals articulated in the Quality Strategy -- to improve

health care access, efficiency, engagement, and outcomes, while addressing health disparities. Likewise, WHA fully supports the strategies outlined -- to investigate improved models for payment, care coordination, and usage of health information technology. Expansion of the managed care model has been a clear and consistent strategy for the State's Medicaid program. The successful implementation of an innovative, long-term, strategic managed care vision must include meaningful involvement and dialogue with the stakeholder groups ultimately responsible for operationalizing the strategy. WHA and our members welcome the opportunity to partner with the Department of Health Services (DHS) to devise a detailed implementation strategy. WHA members are particularly interested in the aspects of the proposal noted below.

Quality Strategies

WHA supports the use of well-designed pay-for-performance (P4P) programs. WHA has also been a strong advocate for recently-signed, as well as previously enacted, legislation promoting care coordination programs. In both instances, it will be crucial to engage the provider perspective to thoughtfully execute these initiatives in a managed care structure.

Data & Technology

Data is vital to providing quality patient care, evaluating trends, and understanding program effectiveness. Technology providing access to patient information is a necessity in the efficient, effective delivery of health care. WHA welcomes the opportunity to discuss strategies to optimize the exchange of patient information to improve care coordination. WHA has also made repeated requests to combine the power of the WHA Information Center (WHAIC) with Medicaid claims data to create a robust warehouse of data to inform care delivery and program development and evaluation.

Managed Care

WHA supports the Quality Strategy commitment to enhanced transparency and public reporting of Managed Care Organization (MCO) performance. To be effective, MCO performance data must be easily understandable and accessible to members and advocates and the performance data must be timely. Performance reporting should not only include P4P outcomes but information pertaining to contract compliance and member engagement, satisfaction and access.

Managed care contract requirements and performance incentives are generally developed by DHS in collaboration with the MCOs, but this approach can lead to the misalignment of goals, responsibilities and incentives between managed care issuers and providers. Again, WHA encourages DHS to engage broad stakeholder input in developing this feature of the Quality Strategy.

Quality Assurance

WHA has been heavily involved in State-level discussions on network adequacy, with a focus on transparency, compliance, and consistency. It will be optimal for the DHS strategy to conform with existing state and federal regulations and requirements, and to coordinate with the ongoing parallel discussions on this topic. WHA welcomes the opportunity to provide input and share our members' perspective.

In Wisconsin and elsewhere, health care delivery is in a state of continuous improvement and evolution. As such, WHA has encouraged our membership to think creatively “beyond the hospital walls”, across strategic partnerships, and along the continuum of care as we consider our own long term strategic vision. The health care delivery system is an interconnected web of stakeholders with valuable perspectives to contribute to the development of an achievable long-term Medicaid strategy for the State of Wisconsin. We appreciate this opportunity to comment on the Quality Strategy and look forward to engaging in the difficult work that lies ahead to turn the conceptual into reality.

f. Accreditation Plan

The Accreditation Plan can be found on the ForwardHealth Portal at [https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality for BCP and Medicaid SSI/Home.htm.spage](https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality%20for%20BCP%20and%20Medicaid%20SSI/Home.htm.spage).

g. Supporting Documents for CMS Compliance Matrix Detail

BadgerCare Plus and SSI HMO Contract:

<https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Contracts/Home.htm.spage>

Family Care and Family Care Partnership Contract: <https://www.dhs.wisconsin.gov/familycare/mcos/2018-generic-final.pdf>

BadgerCare Plus and SSI HMO Quality Guide:

[https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality for BCP and Medicaid SSI/Home.htm.spage](https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality%20for%20BCP%20and%20Medicaid%20SSI/Home.htm.spage)

Long-Term Care Quality Reports: <https://www.dhs.wisconsin.gov/familycare/reports/index.htm>