WISCONSIN DEPARTMENT *of* HEALTH SERVICES

2021 MEDICAID MANAGED CARE QUALITY STRATEGY

June 2021

STATE OF WISCONSIN

Contents

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, activities intended to achieve the goals, and the process for monitoring progress toward these goals, are described in the Wisconsin Medicaid Managed Care Quality Strategy document (Quality Strategy). Definitions for commonly used terms in the Wisconsin Medicaid Managed Care Quality Strategy can be found in the Glossary in Section 8.

The Quality Strategy was prepared by DMS in accordance with requirements from the 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 complies with the federal Medicaid managed care rule, 42 C.F.R. § 438.340 requirements.

In Wisconsin, acute care services for managed care members are furnished by BadgerCare Plus and Supplemental Security Income (SSI) health maintenance organizations (HMOs). Additionally, there are three managed care prepaid inpatient health plans (PIHPs) providing acute care services to youth with special needs through the Children Come First, Wraparound Milwaukee, and Care4Kids programs. 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 (PIHPs). Family Care Partnership MCOs are also capitated to administer acute care services. For the purposes of this Quality Strategy, the term PIHPs is used to refer to both MCOs and the Children Come First, Wraparound Milwaukee, and Care4Kids programs. 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.

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

Payment: DMS is using value-based reimbursement arrangements to align payments to outcomes. These arrangements include pay-for-performance initiatives for clinical measures, member satisfaction scores, member engagement in Competitive Integrated Employment, quality of Assisted Living Communities; and reducing potentially preventable hospital readmissions.

Delivery system and person-centered care: Delivery system strategies focus on the way HMOs, PIHPs, 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 and emphasize high-quality, evidence-based, accessible care in which individual needs, preferences, and values of members and caretakers are paramount.

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

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 (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 establishes 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 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 it 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. 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. Additional acute managed care programs include those prepaid inpatient health plans (PHIPs) serving youth with special needs enrolled in Children Come First, Wraparound Milwaukee, and Care4Kids. 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), also referred to as pre-paid inpatient health plans (PIHPs). The Family Care Partnership program also covers acute and primary care services. DMS also has dedicated long-term care teams that manage the long-term care PIHPs. Although there is alignment and substantial overlap between acute care and long-term care program goals, objectives, and strategies, some divergence is 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.

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

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, 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. In 2018, adults with SSI coverage who were not eligible for waiver or nursing-home level services and not dually-covered by Medicare were enrolled in SSI HMOs, which significantly increased managed care program size. Wisconsin has statewide coverage for BadgerCare Plus and Medicaid SSI programs, with multiple HMOs for members to choose from in each county.

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. In July 2018, Family Care expanded statewide. As of March 2021, the Family Care programs reached full entitlement. Family Care will continue to provide all Medicaid-covered long-term care services and supports 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.

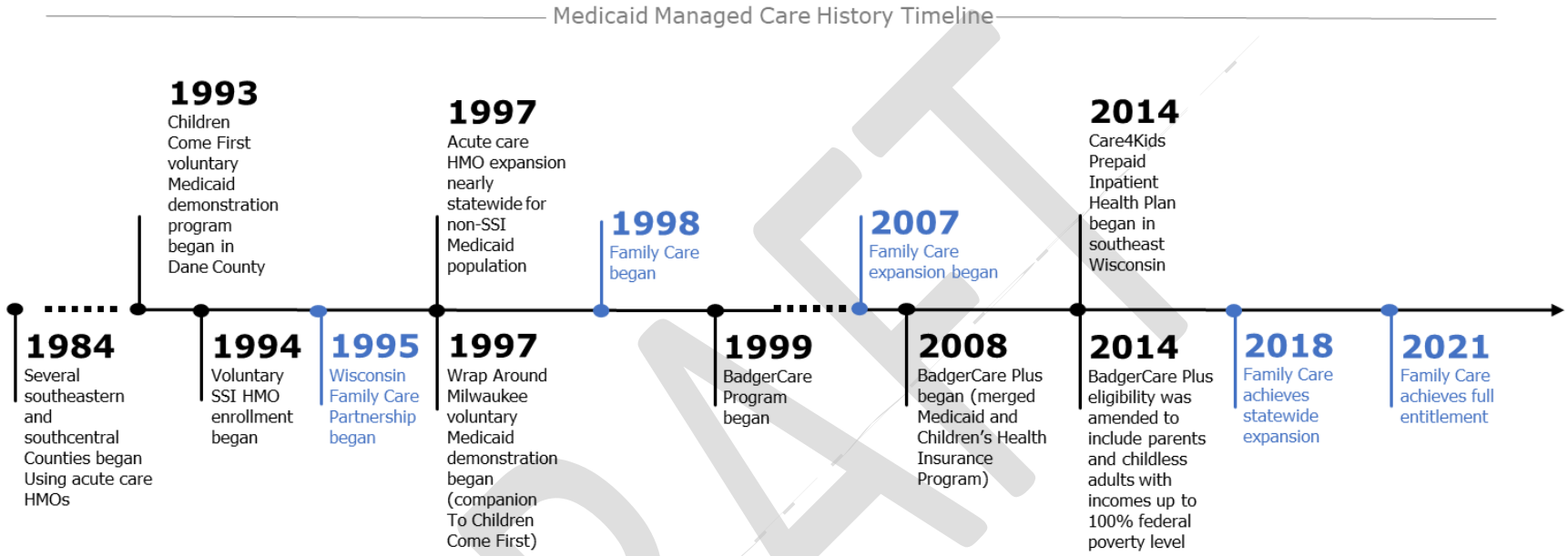

FIGURE 2

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 April 26 through May 21, 2021 for comment by stakeholders and the public through a number of outreach efforts. These outreach efforts include presentation to advisory committees and councils, tribal consultation, publication on the DHS website, newspaper announcement, and GovD notice. Following the 30-day public comment period, all feedback will be reviewed and included in the final Quality Strategy publication. Appendix 8e will include a summary of comments received on 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 reviews and updates 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 submit to CMS.

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.
- Hold accountability 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, measures, 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 members' 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)

Considering the DHS and DMS Vision, Mission, and Foundational Principles, specific goals and objectives were identified to support continuous improvement and ongoing effectiveness evaluation of the quality strategy in achieving the DMS mission. The revised DMS Quality Goals and Objectives in this 2021 Quality Strategy reflect a continuous improvement effort in the selection of specific and measureable goals, which DMS will be able to evaluate improvement on over time.

DMS monitors a wide array of input, process, and outcome measures for its managed care programs. The Quality Strategy prioritizes a manageable set of goals and objectives that are tied to measures focused on member outcomes, accurately measured, reliably reported, and actionable for quality improvement. One factor in the selection of the quality strategy performance measures was consideration for those endorsed by a national quality organization. Measures endorsed by a national quality organization, such as the National Committee for Quality Assurance (NCQA), signify a high standard for consistency and validity in performance measurement and present an opportunity to compare results on standard measures with national results. The CMS Adult Core Set and Child Core Set provide a foundation for the selection of performance measures supporting the acute and primary care goals and objectives. Similarly, the CMS Recommended Measure Set for Medicaid-Funded Home and Community-Based Services provides a foundation for the selection of performance measures supporting the long-term care goals and objectives. Also included are performance indicators for the Care4Kids program, which are presented in their own table.

Considering these factors, 12 performance measures were identified for acute and primary care, and 17 performance measures were identified for long-term care. DMS also monitors quality outcomes for the Care4Kids, Children Come First, and Wraparound Milwaukee PIHPs, and these quality outcomes are aligned with the Goals and Objectives described in the tables that follow. To reference other quality measures for each program, see the Quality Measure Matrix in Appendix 8c.

The Goals and Objectives tables below (Table 1 and Table 3) describe the relationship between the quality domains, goals, objectives, and data sources. Annual statewide average trend data for each objective is provided in the table to provide a sense for improvement over time. Data from 2017 to 2019 reflects the most recent statewide average performance for each measure. The Quality Measures Baseline Data tables (Table 2 and Table 4) present the most recent result for each quality measure within the context of a national comparison. In the Acute and Primary Care Quality Measures Baseline Data table (Table 2), the National Quality Compass percentile data is presented to give context to how state results compare to national results. In the Long-Term Care Quality Measures Baseline Data table (Table 4), the NCI National Average result is presented as

a comparison with the state result for each measure. These data provide a sense for how Wisconsin performs in relation to national performance on the same measures.

TABLE 1. ACUTE AND PRIMARY CARE GOALS AND OBJECTIVES

ACUTE AND PRIMARY CARE		
Primary Care Access and Preventive Care		
Goal 1: Provide access to primary care and preventive services to maintain wellbeing, identify health concerns, and ensure timely intervention.	**Improve outcomes on the following measures:** **Objective 1a:** Adolescent Well-Care Visits* • 2017: 43.3% • 2018: 44.7% • 2019: 47.4% **Objective 1b:** Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* • 2017: 66.0% • 2018: 64.8% • 2019: 67.9% **Objective 1c:** Well-Child Visits in the First 15 Months of Life (6 or more visits)** • 2017: 57.0% • 2018: 58.4% • 2019: 60.0% **Objective 1d:** Childhood Immunization Status (Combo 3) • 2017: 70.8% • 2018: 71.5% • 2019: 71.3% **Objective 1e:** Immunizations for Adolescents (Combo 2) • 2017: 33.0% • 2018: 39.0%	**Data Source:** CMS Child Core Set NCQA HEDIS Measures Objective 1a. AWC-CH* Objective 1b. W34-CH* Objective 1c. W15-CH** Objective 1d. CIS-CH (Combo 3) Objective 1e. IMA-CH (Combo 2) *AWC-CH and W34-CH have been modified into a new combined measure due to changes in the 2021 CMS Child Core Set. These measures will be replaced by Child and Adolescent Well-Care Visits (WCV-CH) starting 2021. **W15-CH has been modified to include an additional rate in the measure due to changes in the 2021 CMS Child Core Set. This measure will be replaced by Well-Child Visits in the First 30 Months of Life (W30-CH) starting 2021.

	• 2019: 40.5%	
Maternal and Perinatal Health		
Goal 2: Set the stage for healthy birth outcomes and long-term well-being of mothers and infants.	**Improve outcomes on the following measures:** **Objective 2a:** Prenatal and Postpartum Care: Timeliness of Prenatal Care • 2017: 80.6% • 2018: 84.0% • 2019: 89.2% **Objective 2b:** Prenatal and Postpartum Care: Postpartum Care • 2017: 67.3% • 2018: 65.5% • 2019: 76.5%	**Data Source:** CMS Child Core Set CMS Adult Core Set NCQA HEDIS Measures Objective 2a. PPC-CH Objective 2b. PPC-AD
Care of Acute and Chronic Conditions		
Goal 3: Provide support to manage chronic conditions and reduce adverse acute outcomes.	**Improve outcomes on the following measure:** **Objective 3:** Controlling High Blood Pressure • 2017: 56.9% • 2018: 64.7% • 2019: 64.3%	**Data Source:** CMS Adult Core Set NCQA HEDIS Measure Objective 3. CBP-AD
Behavioral Health Care		
Goal 4: Promote early intervention for substance use and timely follow-up care for behavioral health concerns.	**Improve outcomes on the following measures:** **Objective 4a.** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Engagement) • 2017: 9.4% • 2018: 10.0%	**Data Source:** CMS Adult Core Set NCQA HEDIS Measures Objective 4a. IET-AD (Engagement) Objective 4b. FUA-30* Objective 4c. FUM-30* Objective 4d. FUH-30

	• 2019: 11.7% **Objective 4b.** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 Days) • 2017: 15.5% • 2018: 16.8% • 2019: 16.0% **Objective 4c.** Follow-Up After Emergency Department Visit for Mental Illness (30 Days) • 2017: 42.2% • 2018: 55.7% • 2019: 60.6% **Objective 4d.** Follow-Up After Hospitalization for Mental Illness (30 Days) • 2017: 54.9% • 2018: 54.9% • 2019: 58.9%	*2017 rates for FUA-30 and FUM-30 are limited to reporting by 14 of 19 HMOs.

For more details on the performance measures associated with the acute and primary care goals and objectives, see Table 2, which demonstrates baseline performance measure results alongside the National 2019 Bottom, Middle, and Top Quartiles for each measure. National quartile data are retrieved from the NCQA Quality Compass. These quartiles, along with the statewide average rate in some cases, are used to set HMO performance targets in the HMO Pay-for-Performance initiative.

Other acute and primary care performance measures are regularly monitored and included in the initiatives described below:

- The **Pay for Performance (P4P)** initiative focuses on improving measurable quality of care for Medicaid members. Its current scope includes HMOs, with applicable capitation withholds that can be earned back by HMOs based on their performance relative to quality targets for selected measures applicable to them. These measures relate to priority areas for DMS; as such, the performance measures associated with the Managed Care Quality Strategy Goals and Objectives are the Pay for Performance measures in place as of 2020. DMS continues to move from Process-only measures to a combination of Process and Outcome measures - e.g., from HbA1c testing to HbA1c Control, related to diabetes care.

- The **Wisconsin Core Reporting (WICR)** initiative focuses on providing DMS healthcare quality data for a broad set of conditions and measures that are related to Medicaid Core Sets published by CMS. It does not include a withheld financial amount but requires HMOs to report data on specific quality measures, and imposes financial penalties for not reporting results. DHS submits P4P and WICR results to CMS, and CMS publishes an annual scorecard of state performance. Results for all the above quality measures are used as input for the DMS HMO Report Cards. The HMO Report Card is publicly available on the DMS website (www.forwardhealth.wi.gov).
- The **Potentially Preventable Readmission** (**PPR)** initiative focuses on reducing preventable hospital readmissions following an initial admission. Excess readmissions compared to statewide benchmarks suggest an opportunity to improve patient outcomes and to reduce costs through better discharge planning, better coordination of care across sites of service, and/or other improvements in the delivery of care.
- The **SSI Care Management** initiative aims to provide person-centric care through needs stratification, integration of social determinants, person-centric care plans, interdisciplinary care teams, and an on-going assessment and alignment of the SSI members' needs with their care.
- The **Health Disparities Reduction Performance Improvement Project (PIP)** initiative focuses on reducing health disparities among Medicaid members, improving cultural competence of HMOs and providers serving Wisconsin Medicaid members, and compliance with the Managed Care Rule requirement defined in 42 CFR 438.340 (b).
- **HealthCheck** (Wisconsin's EPSDT Program – Early and Periodic Screening, Diagnostic and Treatment program) is a preventive health check-up program for anyone under the age of 21 who is currently eligible for Wisconsin Medicaid or BadgerCare Plus.
- **CAHPS** is a survey tool used by DHS to survey both fee-for-service and HMO member experience and satisfaction with care. The survey is administered annually to children in BadgerCare Plus or CHIP populations, and data is shared with CMS.

TABLE 2. ACUTE AND PRIMARY CARE QUALITY MEASURES BASELINE DATA

Measure Name	Measure Specifications	Baseline (2019)	National Bottom Quartile (25th)	National Median Quartile (50th)	National Top Quartile (75th)	Program	
						BC+	SSI
Adolescent Well-Care Visits (AWC-CH)*							
Adolescent Well-Care Visits	Child Core Set	47.4%	48.4%	57.2%	64.7%	x	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34-CH)*							
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Child Core Set	67.9%	68.6%	74.7%	80.3%	x	
Well-Child Visits in the First 15 Months of Life (W15-CH)**							
Well-Child Visits in the First 15 Months of Life - 6 or more visits	Child Core Set	60.0%	61.3%	67.9%	73.0%	x	
Childhood Immunization Status (CIS-CH)							
Childhood Immunization Status - Combo 3	Child Core Set	71.3%	66.7%	71.1%	75.2%	x	
Immunizations for Adolescents (IMA-CH)							
Immunizations for Adolescents - Combo 2	Child Core Set	40.5%	31.0%	36.9%	43.1%	x	
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)							
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Child Core Set	89.2%	84.2%	89.1%	92.9%	x	
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)							
Prenatal and Postpartum Care: Postpartum Care	Adult Core Set	76.5%	71.3%	76.4%	80.9%	x	
Controlling High Blood Pressure (CBP-AD)							
Controlling High Blood Pressure	Adult Core Set	64.3%	54.0%	61.8%	67.6%		x

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)							
Alcohol Abuse or Dependence who Initiated Alcohol or Other Drug Treatment – Engagement Total	Adult Core Set	11.7%	9.7%	14.2%	18.6%		x
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)							
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – Total 30-day follow-up	Adult Core Set	16.0%	10.8%	19.3%	27.8%		x
Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)							
Follow-Up After Emergency Department Visit for Mental Illness – Total 30-day follow-up	Adult Core Set	60.6%	46.8%	55.2%	65.4%		x
Follow-Up After Hospitalization for Mental Illness (FUH-AD)							
Follow-Up After Hospitalization for Mental Illness – 30 Days	Adult Core Set	58.9%	50.0%	59.2%	67.0%		x

*AWC-CH and W34-CH have been modified into a new combined measure. They will be replaced by Child and Adolescent Well-Care Visits (WCV-CH) starting 2021.

**W15-CH has been modified to include an additional rate in the measure. It will be replaced by Well-Child Visits in the First 30 Months of Life (W30-CH) starting 2021.

TABLE 3. LONG-TERM CARE GOALS AND OBJECTIVES

LONG-TERM CARE		
Care Plan and Services		
Goal 1: Service Delivery and Effectiveness Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes.	**Objective 1a.** Increase the percentage of people who know whom to ask if they want to change something about their services. • 2016-2017: N/A* • 2017-2018: 81% AD • 2018-2019**:** 81% IPS / 79% AD *This was a new question for the IPS survey starting 2018-2019. **Objective 1b.** Increase the percentage of new MLTSS enrollees whose care is initiated within one day of enrollment • 2017: 92.5% FC, 83.7% FCP • 2018: 92.8% FC, 83.7% FCP • 2019: 91.4% FC, 79.0% FCP	**Data Source 1a:** National Core Indicators: In-Person Survey (IPS) • NCI-51 National Core Indicators: Aging and Disabilities (AD) Survey • NCI-AD-11 **Data Source 1b:** State enrollment and encounter data
Goal 2: Person-Centered Planning and Coordination Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values.	**Objective 2a.** Comprehensiveness of Assessment • 2016-2017: 88.9% FC*, 93.3% FCP** • 2017-2018: 86.9% FC, 84.4% FCP • 2018-2019: 97.1% FC, 96.7% FCP **Objective 2b.** Comprehensiveness of Most Recent Member Centered Plan (MCP) • 2016-2017: 40.4% FC, 51.1% FCP	**Data Source:** External Quality Review Annual Technical Report: Care Management Review Items 1A and 2A

	• 2017-2018: 55.3% FC, 70.0% FCP • 2018-2019: 68.1% FC, 73.3% FCP *FC: Family Care **FCP: Family Care Partnership	
Goal 3: Choice and Control Empower individuals to, on their own or with support, make life choices, choose their services and supports, and control how those services and supports are delivered.	**Objective 3.** Increase the percentage of people who can choose their services. • 2016-2017: 73% IPS • 2017-2018: 75% IPS / 72% AD • 2018-2019**:** 64% IPS / 58% AD	**Data Source:** National Core Indicators: In-Person Survey (IPS) • NCI-50 National Core Indicators: Aging and Disabilities (AD) Survey • NCI-AD-33
Goal 4: Equity Provide equitable access to services and supports.	**Objective 4.** Increase the percentage of non-English speaking participants who receive information about their services in the language they prefer. • 2016-2017: N/A • 2017-2018: 86% AD • 2018-2019: 87% AD	**Data Source:** National Core Indicators: Aging and Disabilities (AD) Survey: • NCI-AD-17
Community Engagement		
Goal 5: Community Inclusion Provide the opportunity for people to be integrated into their communities and socially connected, in accordance with their personal preferences.	**Objective 5a.** Increase the percentage of people who have transportation when they want to do things outside their home. • 2016-2017: 86% IPS • 2017-2018: 78% IPS / 78% AD • 2018-2019**:** 71% IPS / 68% AD **Objective 5b.**	**Data Source 5a:** National Core Indicators: In-Person Survey (IPS) • NCI-56 National Core Indicators: Aging and Disabilities (AD) Survey • NCI-AD-22 **Data Source 5b:**

	Increase the percentage of people who work in non-workshop settings. • 2016: 22.3% I/DD* / 3.4% PD** • 2017: 21.9% I/DD / 3.3% PD • 2018: 22.1% I/DD / 3.3% PD **Objective 5c.** Increase the percentage of people who are as active in their community as they would like to be • 2016-2017: 32% IPS • 2017-2018: 38% IPS / 47% AD • 2018-2019**:** 33% IPS / 46% AD *I/DD: Intellectual and/or Developmental Disability **PD: Physical Disability	Wisconsin Long-Term Care Scorecard Report: 2015-2017 • Indicator 3.1.2 (I/DD) • Indicator 3.1.3 (PD) **Data Source 5c:** National Core Indicators: In-Person Survey (IPS) • NCI-66 National Core Indicators: Aging and Disabilities (AD) Survey • NCI-AD-1
Caregiver Support and Workforce		
Goal 6: Caregiver Support Offer financial, emotional, and technical support for family caregivers or natural supports of individuals who use HCBS.	**Objective 6.** Increase the percentage of adults living with spouse and/or family receiving unpaid care who also receive respite. • 2016: 12.9% • 2017: 12.2% • 2018: 12.1%	**Data Source:** Wisconsin Long-Term Care Scorecard Report: 2015-2017 • Indicator 4.2
Goal 7: System Performance and Accountability Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.	**Objective 7a.** Increase the percentage of total Long-Term Services and Supports (LTSS) Medicaid funding spent on the care and support of adult enrollees in a Home and Community Based Services (HCBS) waiver • 2016: 75.0% • 2017: 76.9%	**Data Source 7a:** Wisconsin Long-Term Care Scorecard Report: 2015-2017 • Indicator 1.2 **Data Source 7b:** Wisconsin Long-Term Care Scorecard Report: 2015-2017

	• 2018: 78.9% **Objective 7b.** Increase the percentage of eligible Medicaid adults enrolled in HCBS Waivers • 2016: 81.7% • 2017: 83.4% • 2018: 84.8%	• Indicator 2.1
Goal 8: Workforce Ensure the HCBS workforce is adequate, available, and appropriate to serve the needs of people who use HCBS.	**Objective 8.** Increase the percentage of people whose support staff treat them with respect. • 2016-2017: 89% IPS • 2017-2018: 93% IPS / 88% AD • 2018-2019**:** 89% IPS / 84% AD	**Data Source(s):** National Core Indicators: In-Person Survey (IPS) • NCI-53 National Core Indicators: Aging and Disabilities (AD) Survey • NCI-AD-27
Goal 9: Human and Legal Rights Promote and protect the human and legal rights of individuals who use HCBS.	**Objective 9.** Increase the percentage of people who feel safe around their support staff. • 2016-2017: 96% IPS • 2017-2018: 93% IPS / 96% AD • 2018-2019**:** 91% IPS / 94% AD	**Data Source(s):** National Core Indicators: In-Person Survey (IPS) • NCI-18 National Core Indicators: Aging and Disabilities (AD) Survey • NCI-AD-24
Goal 10: Consumer Leadership in System Development Support individuals who use HCBS to actively participate in the design, implementation, and evaluation of the system at all levels.	**Objective 10.** Increase the percentage of people who participate in the annual member satisfaction survey. • 2018: 42.6% FC, 36.8% FCP • 2019: 39.5% FC, 30.0% FCP • 2020: 44.7% FC, 27.0% FCP	**Data Source(s):** Member Satisfaction Survey

Well-Being		
Goal 11: Holistic Health and Functioning Assess and support all dimensions of holistic health.	**Objective 11a.** Increase the percentage of people who receive vaccinations. • Flu Vaccination: o 2017: 71.9% o 2018: 71.7% o 2019: 73.7% • Pneumococcal Vaccination: o 2017: 84.5% o 2018: 87.2% o 2019: 90.1% **Objective 11b.** Decrease the percentage of people whose self-reported health is poor. • 2016-2017: 4% IPS • 2017-2018: 6% IPS / 17% AD • 2018-2019**:** 6% IPS / 17% AD	**Data Source 11a:** CMS 372 Report **Data Source 11b:** National Core Indicators: In-Person Survey (IPS) • NCI-97 National Core Indicators: Aging and Disabilities (AD) Survey • NCI-AD-64

The goals and objectives in the table above reflect a subset of performance measures used by the DMS for quality improvement. For more details on these measures, see Table 4 below. Other performance measures are regularly monitored and included in the initiatives described below:

- **MCO Satisfaction Survey** – On an annual basis, MCO members are invited to provide feedback on their experience with their MCO. Satisfaction Survey results provide insight on members' perception of care team responsiveness and quality of communication, level of member engagement in care plan development, and how well supports and services address the member's needs. DMS partners with the University of Wisconsin-Madison Survey Center to develop, implement, and improve this standardized survey instrument. The first MCO Satisfaction Survey was implemented in 2018.
- **National Core Indicators (NCI) Surveys** – Wisconsin participates in the NCI In-Person Survey (IPS) and NCI Aging and Disabilities (AD) surveys; consumer participation is voluntary and randomly selected statewide. The IPS survey assesses consumers with intellectual or developmental disabilities, and the AD survey assesses consumers who have physical disabilities or who are older adults, (age 65 years or older). Consumer participation in the NCI surveys is not limited to MCO members and includes other beneficiaries of the LTSS system, including Include, Respect, I Self-Direct (IRIS) enrollees and PACE enrollees. The core indicators are standard measures used across states to assess quality of life and the outcomes of services provided to individuals. Indicators address key areas including service planning, rights, community inclusion, choice, health and care coordination, safety, and

relationships. Wisconsin's first statewide participation in the NCI-IPS survey was 2015-2016 and the NCI-AD survey in 2017-2018. Both surveys have had consistent sampling methodology since 2017-18 in regards to oversampling by program and target groups. The NCI AD survey presents break out tables for these groups while the IPS survey presents aggregate results of all groups.

- **External Quality Review Organization (EQRO) Quality Compliance Review and Care Management Review** – The DMS External Quality Review Organization (EQRO) conducts reviews reported in the Annual Technical Reports to assess PIHP compliance with federal standards and state contractual requirements. The Quality Compliance Review assesses the extent to which each PIHP's policies, processes, and procedures meet state standards for compliance and quality improvement. The Care Management Review helps determine a PIHP's level of compliance with its contract with DHS; ability to safeguard members' health and welfare; and ability to effectively support care management teams in the delivery of cost effective, outcome-based services. The results of these EQRO reviews give DMS a sense for the PIHPs' level of infrastructure and consistency necessary to support quality improvement.
- **Adult Long Term Care Scorecard Report** – The Wisconsin Long Term Care Scorecard Report is designed to inform and advise policymakers, consumers, advocates, and the general public of the strengths and weaknesses in the long-term services and supports (LTSS) system. It is modeled after a national scorecard ranking states on their LTSS systems for elderly and physically disabled adults. This national scorecard serves as a tool for providing comparable data on each state's LTSS system performance. The latest version is called Advancing Action.
- **Performance Improvement Projects (PIPs)** – Family Care and Family Care Partnership PIHPs are contractually required to identify and conduct two performance improvement project per year (Article XII.C.7) in alignment with CMS External Quality Review Protocol 1 (October 2019; https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf). All PIPs are annually validated by the DHS-contracted external quality review organization.
- **Pay for Performance Initiatives –** DMS currently implements three Pay for Performance initiatives for the Family Care and Family Care Partnership programs. Pay for Performance initiatives involve withhold and incentive arrangements used to encourage PIHPs to drive improvements in prioritized program areas. Current Pay for Performance initiatives focus on increasing member engagement in Competitive Integrated Employment (CIE), improving the quality of Assisted Living Communities (ALCs), and improving member satisfaction.

TABLE 4. LONG-TERM CARE QUALITY MEASURES BASELINE DATA

Measure Name	Measure Specifications (2018-2019)*	Baseline Performance (2018-2019)*	NCI National Average**	Program	
				FC	FCP
Percentage of people who know whom to ask if they want to change something about their services					
NCI 51: Percentage of people who know whom to ask if they want to change something about their services	NCI-IPS	81%	83%	x	x
NCI-AD-11: Percentage of people who know whom to contact if they want to make changes to their services	NCI-AD	79%	80%	x	x
Percentage of new MLTSS enrollees whose care is initiated within one day of enrollment					
Percentage of new MLTSS enrollees whose care is initiated within one day of enrollment	State enrollment and encounter data (2019)	91.4% FC 79.0% FCP	80%	x	x
Comprehensiveness of Assessment					
1A: Comprehensiveness of Assessment	EQRO Care Management Review	97.1% FC 96.7% FCP	-	x	x
Comprehensiveness of Most Recent MCP					
2A: Comprehensiveness of Most Recent MCP	EQRO Care Management Review	68.1% FC 73.3% FCP	-	x	x
Percentage of people who can choose their services					
NCI 50: The percentage of people who say they were able to choose the services they get as part of their service plan	NCI-IPS	64%	73%	x	x
NCI-AD-33: Percentage of people who can choose or change what kind of services they get	NCI-AD	58%	64%	x	x

Percentage of non-English speaking participants who receive information about their services in the language they prefer					
NCI-AD-17: Percentage of non-English speaking participants who receive information about their services in the language they prefer	NCI-AD	87%	89%	x	x
Percentage of people who have transportation when they want to do things outside their home					
NCI 56: Percentage of people who have a way to get to places they want to go (for fun, visit others, or to get out of their home)	NCI-IPS	71%	82%	x	x
NCI-AD-22: Percentage of people who have transportation when they want to do things outside of their home	NCI-AD	68%	72%	x	x
Percentage of people who work in non-workshop settings					
3.1.2: Percentage of adults in the I/DD population working in a nonworkshop setting	Wisconsin Long-Term Care Scorecard Report (2017)	24%	-	x	x
3.1.3: Percentage of adults in the PD population working in a nonworkshop setting	Wisconsin Long-Term Care Scorecard Report (2017)	3.4%	-	x	x
Percentage of people who are as active in their community as they would like to be					
NCI 66: Percentage of people who participate as a member in a community group	NCI-IPS	33%	34%	x	x
NCI-AD-1: Percentage of people who are as active in their community as they would like to be	NCI-AD	46%	49%	x	x
Percentage of adults living with spouse and/or family receiving unpaid care who also receive respite					
4.2: Percentage of adults living with spouse and/or family receiving unpaid care who also receive respite	Wisconsin Long-Term Care Scorecard Report (2017)	12.2%	-	x	x

Percentage of total LTSS Medicaid funding spent on the care and support of adult enrollees in an HCBS Waiver					
1.2 Percentage of total LTSS Medicaid funding spent on the care and support of enrollees in an HCBS Waiver - Adults	Wisconsin Long-Term Care Scorecard Report (2017)	76.9%	-	x	x
Percentage of eligible Medicaid adults enrolled in HCBS Waivers					
2.1 Percentage of eligible Medicaid individuals enrolled in HCBS Waiver Programs - Adults	Wisconsin Long-Term Care Scorecard Report (2017)	83.4%	-	x	x
Percentage of people whose support staff treat them with respect					
NCI 53: Percentage of people who report staff treat them with respect	NCI-IPS	89%	93%	x	x
NCI-AD-27: Percentage of people whose support staff treat them with respect	NCI-AD	84%	91%	x	x
Percentage of people who feel safe around their support staff					
NCI 18: Percentage of people who report they have someone they can talk to if they are ever scared	NCI-IPS	91%	94%	x	x
NCI-AD-24: Percentage of people who feel safe around their support staff	NCI-AD	94%	96%	x	x
Percentage of people who received vaccinations					
% members who received a flu vaccination	2019 CMS 372	73.7%	86%	x	x
% members of 65 who received a pneumococcal vaccination	2019 CMS 372	90.1%	86%	x	x
Percentage of people whose self-reported health is poor					
NCI 97: Percentage of people whose self-reported health is poor	NCI-IPS	6%	3%	x	x
NCI-AD-64: Percentage of people whose self-reported health is poor	NCI-AD	17%	19%	x	x

Percentage of people who have participated in the annual member satisfaction survey					
Percentage of people who have participated in the annual member satisfaction survey	2020 MCO Member Satisfaction Survey	44.7% FC, 27.0% FCP	-	x	x

*Measurement year is 2018-2019, unless otherwise specified in the Measure Specifications column

**National comparison data is available only for NCI-IPS and NCI-AD Survey results.

TABLE 5. FOSTER CARE MEDICAL HOME (CARE4KIDS) GOALS AND OBJECTIVES

FOSTER CARE MEDICAL HOME (Care4Kids)		
Care Plan		
Goal 1: Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values.	**Objective 2.** Timely Comprehensive Initial Health Assessment • 2018: 84% • 2019: 83% • Target: 75% **Objective 6a.** Timely Development of the Comprehensive Health Care Plan • 2018: 98% • 2019: 99% • Target: 100% **Objective 6b.** Timely Update of the Comprehensive Health Care Plan • 2018: 98% • 2019: 99% • Target: 100%	**Data Source:** **Objective 2.** DHS Measure. Target calculated from historical baseline data. **Objective 6.a. and 6b.** DHS Measure. Target calculated from historical baseline data.
Primary Care Access and Preventive Care		
Goal 2: Provide access to primary care and preventive services to maintain wellbeing, identify health concerns, and ensure timely intervention.	**Improve outcomes on the following measures:** **Objective 1.** Timely Out of Home Care Health Screen • 2018: 59% • 2019: 61% • Target: 100% **Objective 4.** Timely Developmental Assessment • 2018: 83% • 2019: 96% • Target: 75% **Objective 7.**	Data Source: **Objective 1.** Member data provided by the program. **Objective 4.** DHS Measure. Target calculated from historical baseline data. Member data provided by the program. **Objective 7.** Member data provided by the program. **Objective 8a. and 8b.**

	Health Check Periodicity • 2018: 77.2% • 2019: 76.8% • Target: 100% **Objective 8a.** Timely Comprehensive Dental Exam at Enrollment • 2018: 73% • 2019: 69% • Target: 45% **Objective 8b.** Timely Comprehensive Dental Exam Periodicity • 2018: 34% • 2019: 35% • Target: 100% **Objective 9.** Blood Lead Testing • 2018: 95% • 2019: 95% **Objective 10a.** Childhood Immunization Status • 2018: 89% • 2019: 92% **Objective 10b.** Immunization for Adolescents • 2018: 89% • 2019: 92%	Dental claims analyzed by DHS partner from data submitted by the program. **Objective 9.** NCQA HEDIS Measure **Objective 10a. and 10b.** NCQA HEDIS Measure
Care of Acute and Chronic Conditions		
Goal 3: Provide support to manage chronic conditions and reduce adverse acute outcomes.	**Improve outcomes on the following measures:** **Objective 12.** Emergency Department Utilization • 2018: 50.68 • 2019: 46.5 **Objective 13.** Inpatient Hospital Utilization • 2018: 2.40% • 2019: 2.36%	**Data Source:** **Objective 12.** NCQA HEDIS Measure **Objective 13.** Member data provided by the program.

Behavioral Health Care		
Goal 4: Promote early intervention for substance use and timely follow-up care for behavioral health concerns.	**Improve outcomes on the following measures:** **Objective 3.** Timely Developmental and/or Mental Health Screen Within 30 Days of Enrollment • 2018: 83% • 2019: 96% • 2020: 60% **Objective 5.** Timely Mental Health Assessment • 2018: 82% • 2019: 87% • 2020: 75% **Objective 11.** Follow-Up After Hospitalization for Mental Health • 2018: 73% • 2019: 72% **Objective 14a.** Baseline Metabolic Monitoring for Children with Antipsychotic Medication Post-Enrollment • 2018: 28% • 2019: 33% **Objective 14b.** Baseline Metabolic Monitoring for Children with Antipsychotic Medication Pre-Enrollment • 2018: 40% • 2019: 24% **Objective 14c.** Timely On-Going Metabolic Monitoring • 2018: 39% • 2019: 28%	**Data Source:** **Objective 3.** DHS Measure. Target calculated from historical baseline data. Member data provided by the program. **Objective 5.** DHS Measure. Target calculated from historical baseline data. Member data provided by the program. **Objective 11.** NCQA HEDIS Measure **Objective 14a., 14b., and 14c**. Claims data provided to the program monthly by DHS partner. Analysis submitted semi-monthly by program.

4. DMS Quality Strategies: § 438.340(b)

The DMS quality strategies are plans and policies designed to achieve the 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 allow DMS to uphold the foundational principle of cost-effectiveness and are utilized to direct focus on key objectives. 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 or governor.

i. Enhance Value-Based Purchasing

BadgerCare Plus and SSI HMOs have specific and increasingly advanced quality measure reporting requirements required of the pay-for-performance initiative. This strategy puts financial incentives and withholds 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. Beginning in 2020 and expanding in 2021 is the use of HMO Performance Improvement Projects (PIPs) focused on reducing health disparities and increasing cultural competence and screening for drivers of health as part of the HMO P4P withhold. This recent expansion of P4P provides financial incentive for HMOs and partner clinics to specifically target identified health disparities in their quality improvement projects.

In 2018, Family Care and Family Care Partnership implemented and completed a pay-for-performance initiative based on results of a member satisfaction survey for recipients of long-term care services. 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. In 2019, Family Care and Family Care Partnership implemented two additional pay-for-performance initiatives focused on Competitive Integrated Employment (CIE) and quality of Assisted Living Communities. Competitive Integrated Employment can improve individuals' quality of life, self-determination, and community engagement. The Assisted Living Communities initiative ensures that, for those members needing care in Community-Based Residential Facilities, Certified Residential Care Apartment Complexes (RCACs), and 3-4 Bed Adult Family Homes (AFHs), services provided meet the highest level of quality standards. Over the next several years, continuing and additional pay-for-

[2] CMS Quality Strategy. Accessed at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Legacy-Quality-Strategy. November 5, 2020.

[3] Working for Quality: The National Quality Strategy. Accessed at: https://www.ahrq.gov/workingforquality/index.html. November 5, 2020.

[4] Quality Payment Program. Accessed at: https://qualitypaymentprogram.cms.gov/. November 5, 2020.

performance initiatives will be implemented to ensure that members are receiving high-quality services and programs as DMS works towards achieving the Triple Aim.

Additionally, DMS implements legislative initiatives to promote access to care. The Wisconsin legislature included a provision in the 2017-2019 state biennial budget for the Direct Care Workforce Initiative to fund increases in the direct care portion of managed long-term care capitation rates. This funding has increased and continued in the 2019-2021 biennial budget. PIHPs receive payments from DHS, which, by contractual obligation, are paid to direct care workers providing adult day care services, daily living skills training, habilitation services, residential care, respite care, supportive home care, and supported employment.

ii. 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 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 PIHPs 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.

During this Quality Strategy period, DMS will evaluate the effectiveness of the PPR initiative using available data to determine next steps for this strategy for 2022 and beyond.

b. Delivery System and Person-Centered Care Strategies

Delivery system strategies focus on the way HMOs, PIHPs, 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.[5] 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, PIHPs, and providers.

[5] IBID

- 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, PIHPs, 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 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 created 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.

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. In the Family Care Partnership program, a licensed nurse practitioner is also part of the interdisciplinary care team. 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 or 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.[6] 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. In this Quality Strategy period, the existing medical

[6]Medicaid.gov. Health Homes. Accessed at: https://www.medicaid.gov/medicaid/ltss/health-homes/index.html November 4, 2017.

and health homes for high-risk pregnant women and those with HIV/AIDS will continue. DMS is expanding health home access by developing a pilot hub and spoke model of coordinated health home care for those with severe substance use disorder, including those members enrolled in managed care.

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 PIHPs. DMS ensures the health and safety of care delivered through BadgerCare Plus HMOs, SSI HMOs, and long-term care PIHPs through contracting requirements and internal and external oversight. This includes oversight of the member grievance and appeal process, including monitoring of information shared by advocates, Ombuds, or other stakeholders working directly with managed care members.

DMS also requires long-term care PIHPs 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:

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 PIHP leadership. These meetings are used to identify and prioritize issues, including policy and system improvement opportunities, and serve as a way to address questions and update HMO and PIHP leadership on contract updates, fiscal updates, and new quality efforts in DMS.

Notably, beginning in early 2020 and on a continuous basis, DMS is collaborating with managed care partners regarding the health and safety of members due to the COVID-19 public health emergency. DMS and managed care plans employed numerous strategies in our pandemic response to ensure members have access to necessary care and services, including COVID-19 testing and immunizations.

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.[7] 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.
- 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.

DMS is planning to launch a HMO Selection Tool through the online member portal and mobile application to more easily enable members to select their HMO and learn about their options, a further improvement to member engagement and experience. During this Quality Strategy period, DMS intends to make improvements to the HMO Report Card used by members to select their high-quality health plan and will seek member input into that process about what information is most helpful for members to actively make enrollment choices.

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)[8] standards self-assessment and to provide information to DMS on how these standards are being integrated into their policies and procedures.

[7] 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.

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

ii. Long-Term Care Choice Strategy

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

Empowering members to choose their long-term care PIHP based on relevant, user-friendly, and transparently reported information is a DMS priority. In 2019, DMS launched its first statewide scorecards[9] for Family Care and Family Care Partnership providing information to consumers on each long-term care PIHP. The scorecards provide transparency on quality outcomes and aid consumers in informed decision-making when selecting a PIHP. The types of information included in the scorecards are member satisfaction results, quality and compliance ratings based on the external quality review organization's Quality Compliance Review, care manager and nurse turnover rates, staff to consumer ratios, availability of tribal care management option, and contact and administrative PIHP information. DMS will continue to improve the statewide scorecards with stakeholder feedback, using available or newly collected data.

The Family Care and Family Care Partnership member-centered approach includes support and guidance from the long-term care PIHPs 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 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 assess and improve the services and outcomes that are being provided and use it to compare Wisconsin to other states on a national level.

Finally, the long-term care choice strategy includes ensuring members can pursue 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[10], an employment best practice guide, and statewide benchmarks, Wisconsin strives to be a leader in providing services and supports that result in competitive integrated employment for individuals who wish to work.

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[9] Information for Members and Potential Members of Family Care, Partnership, and PACE. DHS. Accessed at: https://www.dhs.wisconsin.gov/familycare/help.htm. March 7, 2021.

[10] Guiding Principles for Competitive Integrated Employment (CIE) For People with Disabilities in Long-Term Care. Accessed at: https://www.dhs.wisconsin.gov/publications/p01786.pdf. March 7, 2021.

5. Enabling Infrastructure: Data and Technology

Health information technology and infrastructure play a critical role in enabling and supporting the 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. The Medicaid Management Information System (MMIS), electronic health records, and care management software are examples of health information infrastructure.

Timely access to complete and accurate health data for DMS, providers, HMOs, and PIHPs is essential for the execution of payment and service delivery strategies. DMS acute care and long-term care program areas share many enabling technologies, such as the integrated eligibility determination system known as CARES and the MMIS. Each BadgerCare Plus HMO, SSI HMO, and long-term care PIHP 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 improving statewide health information exchange by requiring all BadgerCare Plus and SSI HMOs to participate in WISHIN (Wisconsin Statewide Health Information Network) by June 2021. Additionally, all SSI HMOs are required to incorporate member care plan information into WISHIN in 2021. These contractual requirements will allow the connection of member's health information (including care plans for SSI members) among physicians, clinics, hospitals, pharmacies, and clinical laboratories across the state of Wisconsin. Adopting such health information exchange leads to faster and better clinical decisions, less duplication, more effective transitions of care, and reduced administrative costs.

DMS is currently modernizing and enhancing its legacy MMIS (Medicaid Management Information System) to compliant CMS modular standards. This includes procurement of a fiscal agent and MMIS contract that will create efficiencies and improvements to our data warehouse and analytics to support data-driven decision-making.

DMS is conducting an assessment of the current state of enabling technology and developing an updated State Medicaid Health Information Technology plan with managed care considerations to enable successful execution of quality improvement strategies supported by technology. DMS is also developing a data management strategy plan which includes provisions for managed care.

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 an 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 if they collect relevant and adequate administrative, clinical, and other data from multiple sources.
- Using the statewide Health Information Exchange (HIE) so that participating payers and providers can access real-time data to improve care coordination and deliver care, regardless of a member's location. In 2021, SSI HMOs are required to share care plan data with the HIE

to allow providers who are not linked to a member's health record sharing access to this information.

- 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 measures 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 help HMOs and PIHPs proactively share information with members about their health status and delivery and quality of care; and encourage members to interact with HMOs, PIHPs, 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. Many HMOs offer mobile applications and/or online patient portals, just as DMS has seen increased adoption of eligibility application and use of the online and mobile eligibility portals. DMS provided increased flexibility to adopt telehealth during the 2020-2021 COVID-19 public health emergency, and is developing permanent policy for coverage of telehealth and remote patient monitoring services, which will provide further member choice and improve access to 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.

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 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.

	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 14 HMOs serving BadgerCare Plus members. 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, core reporting, and other reporting. Further quality assurance requirements are outlined in Section 6.
Activities and Interventions	Payment strategy: • Pay-for-performance and core reporting, including health disparities performance improvement projects • Potentially preventable readmissions Delivery system and person-centered care strategy: • Performance improvement projects • Care Plans Member engagement and choice strategy: • Consumer Assessment of Healthcare Providers and Systems satisfaction survey for children • Public reporting, including website and report cards • Prevalent language rules
Next Steps	DMS will continue focusing on implementing the payment reform strategy in BadgerCare Plus HMOs, through pay-for-performance 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. In 2021, BadgerCare Plus HMOs will continue with their post-partum care disparities performance improvement projects, which will be subject to an increase of the withhold to 1.5%. BadgerCare Plus HMOs and a partner clinic for each will document the current state of screening their members on drivers of health as part of their performance improvement projects in addressing health disparities. Moreover, in 2021, DMS finalized policy to require that by end of 2023, all HMOs obtain a NCQA accreditation for their Medicaid line of business and obtain the NCQA Multicultural Health Care Distinction (MHCD). NCQA Accreditation will streamline regulatory compliance reviews for health plans and help to improve health plan performance on CAHPS and HEDIS measures. The MHCD will allow for consistent review of the National Culturally and Linguistically Appropriate Services (CLAS)

	Standards and data, and to improve health equity and reducing health disparities. DMS has identified opportunities to improve the quality and standardization of BadgerCare Plus and Medicaid SSI HMOs and is in the exploratory phases of several initiatives to create policy during this quality strategy period. These efforts will improve oversight of the HMO program and allow for annual review and updates of our payment reform strategies.

ii. SSI HMOs

Program Description	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. In 2018, enrollment in HMOs became 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 certain waivers or other programs are not eligible for mandatory enrollment. There are currently eight HMOs serving Wisconsin's elderly, blind, or disabled Medicaid and SSI Medicaid members. 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, core reporting, and other reporting. Further quality assurance requirements are outlined in the Quality Assurance Section.
Activities and Interventions	Payment strategy: • Pay-for-performance and core reporting • Potentially preventable readmissions Delivery system and person-centered care strategies: • Performance improvement projects • Care management initiative – needs assessment and stratification, timely and comprehensive care plan, transitional care processes, and enhanced care coordination, including a Wisconsin interdisciplinary care team structure for members with highest needs Member engagement and choice strategy: • Public reporting, including website and report cards • Prevalent language rules

Next Steps	DMS will continue to work with SSI HMOs and the external quality review organization to ensure SSI HMOs achieve compliance with the requirements of the care management model. 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 and sharing data about potentially preventable readmissions. Starting 2021, all SSI HMOs will be required to implement a performance improvement project focused on improving clinical priority measures by identifying and reducing disparities and developing a plan to improve screening members for drivers of health. More information regarding specific performance improvement projects requirements are outlined in the 2020 – 2021 HMO contract and 2021 HMO Quality Guide. Similar to the BadgerCare Plus HMOs, NCQA accreditation for the Medicaid line of business and NCQA's Multicultural Health Care Distinction will be required of all SSI HMOs by the end of 2023. The SSI HMO program will also implement increased member engagement initiatives as a strategy to achieve objectives. DMS has identified opportunities to improve the quality and standardization of BadgerCare Plus and Medicaid SSI HMOs and is in the exploratory phases of several initiatives to create policy during this quality strategy period. These efforts will improve oversight of the HMO program and allow for annual review and updates of our payment reform strategies.

iii. Care4Kids Medical Home

Program Description	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/guardians 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/guardians may enroll or un-enroll their child at any time. 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. Expected outcomes include: • Improved physical and mental health • Improved resiliency • Shorter stays in out-of-home care. These positive outcomes are also expected to result in long-term savings in publicly funded programs.
Activities and Interventions	Delivery system and person-centered care strategy: • 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. DMS will work with Care4Kids and the external quality review organization to ensure Care4Kids achieve compliance with requirements of the care management model. In 2021, DMS will continue requiring implementation of a performance improvement project. More information regarding specific performance improvement projects requirements are outlined in the Care4Kids contract and quality guide. Both the contract and quality guide are evaluated annually and updated as needed to incorporate updates in initiatives, measures, and strategies.

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: • 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, including submission of encounter data following national standards. Each county program has performed significant efforts to adopt and align the federal managed care rule requirements within their program infrastructure and operations over the past two years, which DMS and the EQRO will continue to monitor and evaluate through ongoing operations. DMS will work with Children Come First and Wraparound Milwaukee and the external quality review organization to ensure the programs achieve compliance with requirements of the care management model. In 2021, DMS will continue requiring implementation of a performance improvement project. More information regarding specific performance improvement projects requirements are outlined in the Children Come First and Wraparound Milwaukee contracts.

v. HIV/AIDS Health Home

Program Description	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 condition. Vivent Health is the sole AIDS service organization in Wisconsin. It has locations in Milwaukee, Kenosha, Brown, and Dane counties. In the HIV/AIDS Health Home, Vivent Health provides comprehensive care coordination for eligible individuals across all health care settings and between health and community care settings. Vivent Health has a core team of health care professionals that includes experts in the care and treatment of individuals diagnosed with HIV infection. 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. The HIV/AIDS Health Home is funded through a per-member-per-month care management fee and annual flat fee.
Activities and Interventions	Delivery system and person-centered care strategy: • 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	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 measures for program performance, and coordination of record reviews by DMS and the DHS Division of Public Health.

vi. Obstetrics Medical Home

Program Description	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. There is currently a combined total of 12 BadgerCare Plus and SSI HMOs participating in the Obstetrics Medical Home program. The program's objective is to improve birth outcomes and reduce birth disparities among high-risk pregnant women enrolled in BadgerCare Plus and SSI HMOs by providing enhanced care coordination services. 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).

[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.

Activities and Interventions	Delivery system and person-centered care strategy: • 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 Member engagement and choice: home visits
Next Steps	The Obstetrics Medical Home (OBMH) will continue employing 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. Given Wisconsin's disparate racial birth outcomes, this initiative focuses on delivering culturally and linguistically appropriate services to optimize outcomes and close disparity gaps, especially among its Black/African American member population. During this Quality Strategy period, DMS plans to evaluate this model of care and look for improvement opportunities for coming years.

b. Long-Term Care Programs

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

i. Family Care

Program Description	Family Care, a national model in long-term care, was established in 1998. Currently, DHS contracts with four PIHPs to operate Family Care in 72 counties throughout Wisconsin. Family Care PIHPs provide or coordinate cost-effective and flexible services tailored to each member's needs. DMS provides each Family Care PIHP with a monthly payment for each member and the PIHP 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 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 PIHP will purchase the necessary services for the member.
Activities and Interventions	Payment strategy: pay-for-performance Delivery system and person-centered care strategy: • Performance improvement projects

	• Member-centered care plan • Care management reviews • Independent file review Member engagement and choice strategy: • Member satisfaction survey • Adult long-term care functional screen • PIHP Member Advisory Committee
Next Steps	The Family Care program will continue to focus on quality improvement, including continuing and developing new 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 competitive integrated employment. These activities and interventions, which are and will continue to be implemented in Family Care, are also discussed in the DMS Quality Strategies Section.

ii. Family Care Partnership

Current Program Design	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. Currently, DMS contracts with three PIHPs to operate Family Care Partnership in 14 counties throughout Wisconsin. Family Care Partnership PIHPs 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 acute and primary care coordination through the PIHP. Dual eligible Family Care Partnership members receive Medicare benefits through the PIHP. DHS provides the PIHP with a monthly payment for each member, and the PIHP 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 PIHP will purchase the necessary services for the member.

Activities and Interventions	Payment strategy: pay-for-performance Delivery system and person-centered care: • Performance improvement projects • Member-centered care plan • Care management reviews • Independent file review Member engagement and choice strategy: • Member satisfaction survey • Adult long-term care functional screen • PIHP Member Advisory Committee
Next Steps	The Family Care Partnership program will continue to focus on quality improvement, including continuing and developing new 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 competitive integrated employment. 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.

7. 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, all WI managed care plans are held to standards for access to care. Further detail can be found within Article V of the 2020-2021 BadgerCare Plus and Medicaid SSI HMO contract, Article VIII, Section I of the 2020 Family Care and Family Care Partnership PIHP contract, Article IV, Section KK of the 2020-2021 Wraparound Milwaukee and Children Come First contracts, and Article V of the 2020-2021 Care4Kids contract. These standards are reviewed and updated annually during contracting.

i. Network Adequacy: § 438.340(b)(1)

For all managed care programs, DMS will work towards compliance with the Medicaid managed care rule's requirements in 42 CFR § 438.358 to include the EQRO in network validation, once CMS has published guidance about these requirements. In the interim, each program has specific network adequacy policies and mechanisms to monitor access, as described below.

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 on a monthly basis, which are stored in the

Medicaid Management Information System. DMS reviews the provider networks every year, or more frequently for any requested service area changes or ad hoc access issues. This review includes a provider count and comparison with fee-for-service, and mapping the providers to monitor distance standards for contract compliance.

Long-term care: DMS requires long-term care PIHPs to meet all network adequacy standards required by CMS. These standards require long-term care PIHPs 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 PIHPs 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 PIHP 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 PIHPs 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 PIHPs to develop innovative technological solutions, including telemedicine and e-visits. Within their policies, administration, provider contracts, and service practices, each PIHP 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.

Children's services: PIHPs that serve children are required to meet all network adequacy standards set by CMS and DMS, including distance and waiting times established in the contracts. 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.

DMS is working with PIHPs to develop innovative technological solutions, including telemedicine and e-visits. Within their policies, administration, provider contracts, and service practices, each PIHP 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.

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 PIHPs 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 providers and members upon request. Additional

references regarding adoption of best practices and clinical practice guidelines are in Article IV. DHS currently assesses HMO compliance through review of policies and procedures or a sample of clinical guidelines in the certification application process.

Long-term care: The Family Care and Family Care Partnership PIHP contract describes and defines practice guidelines (Article VII.I.2b) and the benefit packages services (Addendum VII).

Children's services: Article X, Section B10 of the Care4Kids contract, Article X, Section 3b of the Wraparound Milwaukee contract, and Article X, Section 3f of the Children Come First 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 providers and members upon request.

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.

Prior to a member's enrollment in a managed care organization, a long-term care functional screen is conducted to identify a potential member's functional eligibility for the managed long-term care program.[12] The screen provides a foundational baseline of information concerning the level of service, support, and/or health care needs of a potential member. Upon a member's enrollment, Article V, Sections C and D of the 2020 Family Care and Family Care Partnership contract require that managed care organization care management teams collaborate with each member and any member-identified designees toward completion of a comprehensive health (conducted by a registered nurse) and social (conducted by licensed social service coordinator) assessment within 30 days of the member's date of enrollment. This assessment is the primary tool for identification of each member's service, support, and health care needs and provides the basis for the fully-developed member-centered plan within 60 days of the member's date of enrollment. Thereafter, the comprehensive assessment and member-centered plan are reassessed

[12] Wisconsin's Functional Screen. Wisconsin Department of Health Services. Accessed at: https://www.dhs.wisconsin.gov/functionalscreen/index.htm. November 16, 2020.

at least every twelve (12) months (or at a minimum of every six (6) months for a vulnerable/high risk member) with the member and any member-identified designees.

Children's Services: 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. Care4Kids special needs members include individuals who require additional assistance for conditions that may be medical, mental, developmental, physical, or psychological. All members in Children Come First and Wraparound Milwaukee 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: There are several aspects to transitions of care within the BadgerCare Plus and Medicaid SSI HMO program and below is a summary of the contract requirements for HMOs:

- **Loss of providers or subcontracts:** DMS has the ability to require HMOs to submit transition plans, such as member communication plans and care management continuity procedures, for situations where they lose a provider or subcontractor through a contract termination.
- **Contract terminations:** If an HMO decides to terminate its contract with DMS where all members would be transitioned out of the HMO, the HMO has to comply with a transition plan that includes developing a communication plan for HMO members and providers, submitting additional data-sharing reports for transitioning members, and providing timelines for financial reconciliation.
- **New enrollment:** 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. All HMOs are required to submit approved prior authorization data to DMS on a monthly basis to assist with this process. All HMOs must honor out of network prior authorizations to Medicaid-enrolled providers for a period of time, to allow the member to establish in-network care and get a care plan developed by the new HMO.
- **SSI care management:** SSI HMOs are expected to assist with members transitioning out of the highest level of care management into lower care management needs, as well as assist members with emergency room or inpatient facility care transitions. Member care plans should be re-evaluated if the member has transitions between inpatient settings.
- **Transitions for specific conditions:** The contract also requires HMOs to have care management systems and policies and procedures in effect to transition specific populations or conditions. This includes members receiving crisis or other intensive behavioral health services back to in-network community settings, members receiving obstetric medical home care management to post-partum and pediatric care, and between settings transitions for those participating in the HIV/AIDS Health Home. A HMO that identifies a member with a special health care need is also required to share that

information if the member transitions to another health plan or has other coverage, to avoid duplication of services.

- **HMO policies:** Each HMO is required to develop their own policies and procedures regarding transitions of care to meet the requirements defined in the Medicaid managed care rule § 438.62.

Long-term care: Each Family Care and Family Care Partnership PIHP is contractually bound to maintain a transitions of care policy for their agency (Article IV.C.2). The full details of each PIHP'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, PIHPs 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.

Children's Services: Care4Kids (Article III, Section G) as well as Wraparound Milwaukee and Children Come First (Article IV, Section CC) are contractually bound to maintain transitions of care policy for their agency.

iv. Health Disparities

Health disparities are often related to the conditions in which people are born, live, grow, work, and age – also called social determinants of health. Economic resources and geographical location have a proven sizable impact on health outcomes, and so partnerships between communities and the health care system are critical for improving health across the lifespan and reducing disparities in health outcomes. Having data on the unmet social needs of individuals, and using that data to connect to existing community resources and strengthen evidence-based partnerships that improve whole-person health, are foundational to any effort to eliminate disparities. Each of these strategies is described in more detail below.

1. Data Infrastructure

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, sex, 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. However, managed care plans can collect additional data as they provide care management and deliver services to enrolled members to better identify members at risk of poor outcomes. 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.

As part of health disparity reduction efforts, and pursuant to § 438.340, DMS shares member demographic information with BadgerCare Plus and SSI HMOs. Member race, ethnicity, age, sex, primary language data, and disability status is transmitted to BadgerCare Plus and SSI HMOs each month as part of the enrollment file, to the extent the member voluntarily provided it to DMS as part of the eligibility process. Long-term care PIHPs receive member demographic data from functional screen information, which includes race, ethnicity, and disability status. PIHP member target group is also delineated in enrollment data updates provided by long-term care program staff.

At least annually, collected demographic data will be analyzed by the DMS quality team to identify and monitor health disparities. The DMS quality team will engage in a plan, do, study, act process to evaluate current interventions, set future disparities reduction goals, plan and implement future interventions to reduce health disparities, and further refine and facilitate ongoing interventions to continue to address health disparities.

Going forward, BadgerCare Plus and Medicaid SSI HMOs will be required to provide member demographic data (including race and ethnicity) as they report their HEDIS measure performance so that DMS can identify any disparities that exist in the Pay for Performance or WI Core Reporting measures collected annually.

2. Interventions

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 comprehensive assessment, and the HIV/AIDS Medical Home care management system. Additionally, DMS has implemented internal infrastructure to guide ongoing improvements for interventions, including establishing policy advisor positions focusing on health equity and housing insecurity, a DMS-wide Equity and Inclusion Committee, and a project to specifically look at health equity improvements for the HMO program. Strategic managed care health equity goals and performance indicators will align with the priorities championed by the DMS Equity and Inclusion Committee. Other interventions are described in further detail below.

3. Community of Practice on Cultural and Linguistic Competence

DMS engages with external stakeholders on the issues of equity and inclusion in long term services and supports through participation in the Georgetown University Community of Practice on Cultural and Linguistic Competence in Developmental Disabilities (CoP) grant. Selected in 2017 as one of 10 states participating in this 5-year grant program, the CoP engages stakeholders with advocacy, academic, contractor, and DMS perspectives to hold accountability for advancing cross-organization equity initiatives.

4. CLAS Standards

Pursuant to § 438.340(b)(6), the DMS quality strategy incorporates the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) across all its programs in an effort to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status. The DMS

Quality Team uses the National CLAS Standards as its framework to generate and use data to focus and measure efforts that identify disparities and close gaps. Furthermore, National CLAS Standards are used to measure our effectiveness in influencing our vendor and partners' behavior, to support cultural competency, cultural humility, and cultural safety training requirements of our HMOs and providers, and to identify effective policies and best practices that facilitate equity and inclusion.

5. Performance Improvement Projects (PIPs)

In 2021, a Health Disparities Reduction Performing Improvement Project will be initiated by DMS to be implemented by all BadgerCare Plus and SSI HMOs. This initiative is aimed at reducing health disparities, improving cultural competence among HMOs and providers, and encouraging cross-sector partnerships to improve the drivers of health in Wisconsin for BadgerCare Plus and SSI HMOs. The PIP focuses on the following areas:

1. BadgerCare Plus HMOs are required to address disparities in the HEDIS post-partum care measure in an effort to improve the disparities in poor birth outcomes.
2. SSI HMOs are required to identify and address health disparities in a clinical priority topic of their choice, such as the following HEDIS measures (1) adult immunization status, (2) chronic condition management, or (3) behavioral health.
3. HMOs are required to report findings to DMS and develop health disparities reductions plans to improve health measures.

For each project focused on reducing disparities, the HMO must partner with a clinic serving a high volume of target patients, and both parties must complete an organizational self-assessment in cultural competence, develop a plan to reduce disparities, pilot use of non-traditional provider types or services, complete trainings, and conduct a self-assessment on how each screens members for drivers of health.

In long-term care, one PIHP selected a two-year PIP beginning in 2020 focused on improving the quality and consistency of member demographic data reporting in an effort to establish a system for improved baseline data collection for health equity initiatives. In this PIP, screening specialists are required to gather and document member demographic information including, but not limited to, age, race, ethnicity, sex, primary language, and disability target group status during the member's annual screen or if the member has a change in condition. By requiring the completion of these demographic data fields, the PIHP will establish a more comprehensive and culturally informed data infrastructure to work toward health equity goals, including the development of culturally-informed member Prevention and Wellness Plans and clinical practice guidelines.

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

The following outlines the quality assessment and performance improvement programs 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 and further detailed in the

annual HMO Quality Guide. 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 PIHP contract. Based on the requirements, PIHPs 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 l.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 PIHP's quality management program.

Family Care and Family Care Partnership PIHPs have developed intensive quality case management requirements for 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 PIHP 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 PIHP activities, practices, and member care. Oversight team activities include completing intensive record reviews, providing feedback to the PIHPs 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 PIHP and ensure a systematic approach to quality and member care across Wisconsin.

Children's Services: The Quality Assessment Performance Improvement program guidelines are within Article X of the Care4Kids contract and Article IV, Section X of the Children Come First and Wraparound Milwaukee contracts. At a minimum, this program complies with § 438.330(b). Through the Quality Assessment Performance Improvement program, PIHPs 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.

i. Performance Improvement Projects

Acute care: Article X of the BadgerCare Plus and SSI HMO contract and the annual HMO Quality Guide 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 both BadgerCare Plus and SSI are required to submit one performance improvement project for each population, and for 2021, are required to focus on reducing health disparities. 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 PIHPs are contractually required to identify and conduct two performance improvement project per year (Article XII.C.7). Beginning in 2020, PIHPs may choose to design and conduct one or both projects over a given two year contractual period. One performance improvement project must focus on a clinical topic while the second project must have a nonclinical focus. The respective topics must be applicable to member quality improvement needs as assessed by each PIHP. Further, contractual Member Advisory Committees provide an active means for member input related to topic identification and selection.

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 protocols for performance improvement projects[13]. When a performance improvement project is undertaken by each PIHP, the PIHP 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 PIHPs.

In 2020, the PIHPs implemented the following PIPs:

Clinical	Nonclinical
Opioid Education and Wellness	Advance Care Planning Expert Validation - A Process Improvement
Providing enhanced care management services for Family Care Partnership (FCP) members at risk for adverse events related to opioid usage	Advanced Directives – End of Life Planning
A Comprehensive Safety Toolkit for Members Living in Their Own Home	Demographic Data and the Influence on Health Equity
Strengthening the Dementia Screening Triad: Improving member education on the benefits of dementia screening	Optimizing Alignment: Improving Consistency of ADL data in LTCFS and Member Record
Reducing Risk of Acute Care Hospitalization Readmissions for Older Adults through Telephonic Post-Discharge Assessment Utilization	Validating Member Record Consistency: A Critical Step in Accurate Assessment & Care Coordination
Chronic Care Management (foci: diabetes and heart failure)	

Children's Services: PIHPs are contractually required to identify and conduct one performance improvement project per year. The performance improvement project may be applicable to the

[13] Quality of Care External Quality Review. https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html. Accessed March 7, 2021.

member quality improvement needs that are assessed by each PIHP. DMS maintains discretion to require more performance improvement projects per year.

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 contact, Article XII, Section D of the Family Care and Family Care Partnership PIHP contract. Article X of the Care4Kids contract, and Article IV, Section X10 of the Wraparound Milwaukee and Children Come First contracts. The goal of external quality review organization activities is to review and validate whether each HMO and PIHP 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 PIHPs and pre-paid health plans. The external quality review organization findings provide a basis for DMS actions toward HMO or PIHP 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. The EQRO completes an annual report of their oversight activities for each program, which is posted publicly on the DMS' website for transparency. Each PIHP also receives their own individual annual report. While § 438.362 allows for states to exempt plans from EQRO review if they are contracted by both Medicaid and Medicare, DMS does not allow this exemption. All HMOs and PIHPs are subject to EQR0 review.

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, and compliance with the Obstetrics Medical Home program requirements.

For acute care, DMS is requesting CMS approval 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 PIHP performance. DMS also coordinates with the external quality review organization to ensure that the review process addresses changes within the PIHPs, including expansion to new areas and 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 PIHP to develop a remediation plan, and to monitor corrective action on all unmet items as identified in the annual quality review.

Program-wide recommendations from the annual quality review are also taken into consideration by DMS when reviewing and updating the quality strategy and key quality reporting tools. Care Management Review (CMR) results are included in the goals and objectives of the Quality Strategy, and Quality Compliance Review results are included in the annual Family Care and Family Care Partnership scorecards developed by DMS to support consumers in their selection of a PIHP based on aggregated quality ratings.

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 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 FowardHealth website. 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.

Details on sanctions can be found in the BadgerCare Plus and SSI HMO Contract, which is linked in Appendix G. The contract delineates the sanctions and remedial actions imposed on HMOs for violations, breaches, and non-performance of the agreed upon contract. Sanctions administered by the State on HMOs include financial penalties, corrective action requirements, enrollment suspensions and reductions, required reports and data submissions, and modifications or termination of the contract, which are outlined in Article XIV Section D of the HMO Contract.

Long-term care: For Family Care and Family Care Partnership PIHPs, DMS has the authority to impose sanctions or terminate the contract with an PIHP if the PIHP fails to meet performance standards, and has violated or breached the contract between DMS and the PIHP. There are multiple types of sanctions that DMS can impose on the PIHP. Specifics regarding sanctions can be found in Article XVI Section E of the PIHP contract: Sanctions for Violation, Breach, or Non-Performance. The Family Care and Family Care Partnership contract is included in Appendix G.

Children's Services: For PIHP oversight, DMS has the authority, through the Social Security Act Section 1903(m) and Article XIV, Section D of the Care4Kids contract and Article IX of Wraparound Milwaukee and Children Come First contracts to levy sanctions. Sanctions include developing corrective action plans when PIHPs fail to meet performance standards defined in the contract, which may result in financial penalties, enrollment restrictions, temporary management of PIHPs, and termination.

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 PIHP contract outlines intermediate sanctions for failure to comply with the PIHP contract. If and when DMS becomes aware of any potential failures of a PIHP to meet any of its performance expectations under federal or state law or the PIHP contract, the DMS initiates an investigation to determine if any failures have occurred and can accept information relating to its investigation from any source. If the Department determines that a PIHP has failed to meet a performance expectation, the Department will then determine if a sanction is warranted. If the Department determines that a sanction is warranted, it will determine which sanction or sanctions will be imposed and then informs the PIHP and CMS of that via written notices which describe the nature and bases of the sanction and any due process protections that the Department elects to provide the PIHP. The notices would also describe the date when the sanction(s) will

begin. How and when the sanctions will be lifted may or may not be described in the notice depending on the nature of the performance expectation(s) and the type(s) of sanctions imposed. If/when the Department lifts a sanction that it has imposed on a PIHP, it will also provide CMS with notice of that. More specifications in the PIHP contract on administration of sanctions are described in the following paragraphs.

Section E.1 of the Family Care and Family Care Partnership contract states that the Department may impose sanctions (as described under E.3) if it determines that the PIHP has failed to meet any performance expectations (as described under E.2) and that the Department can base its determination on whether to impose sanctions or not on information from any source.

Section E.2 lists the performance expectations that the PIHP can be sanctioned for not meeting. The last performance expectation on the list is broader and includes any performance expectations not specifically listed under E.2 but which the PIHP is required to meet under state or federal law or other provisions of the contract: "The [PIHP] shall meet all other obligations described in federal law, state law, or the contract, not otherwise specifically described, above."

Section E.3 lists the types of sanctions that the Department can impose which includes civil monetary penalties, temporary management of the PIHP, informing members of their right to disenroll, suspension of new enrollments, suspension of payments for members, withholding or recovering capitation payments, terminating the PIHP's contract with DHS, implementing a plan of correction on the PIHP to ensure that the PIHP meets all performance expectations in the future and intensive oversight of the PIHP in order to assist the PIHP come into compliance with performance expectations. Similar to E.2, there is a broad provision that allows the Department to impose any sanction not specifically listed under E.3 that it deems appropriate: "Any other sanction which the Department determines, in its sole discretion, to be appropriate."

Section E.3 also describes the notice that the Department provides to the PIHP when it has determined that it will be imposing a sanction. The notice must describe (1) the basis and nature of the sanction and (2) any due process protections (i.e. appeal rights) the Department elects to provide to the PIHP. The Department is also required to notify CMS both when it imposes a sanction on and PIHP (within 30 days of imposition) and when it lifts a sanction it has imposed on a PIHP (within 30 days of lifting the imposition).

Children's Services: Article XIII, Section C, of the Care4Kids contract and Article XIV, Section C of the Wraparound Milwaukee and Children Come First contracts First 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 PIHP contract.

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. It is a logic model for future evaluation of programs, activities, and interventions.

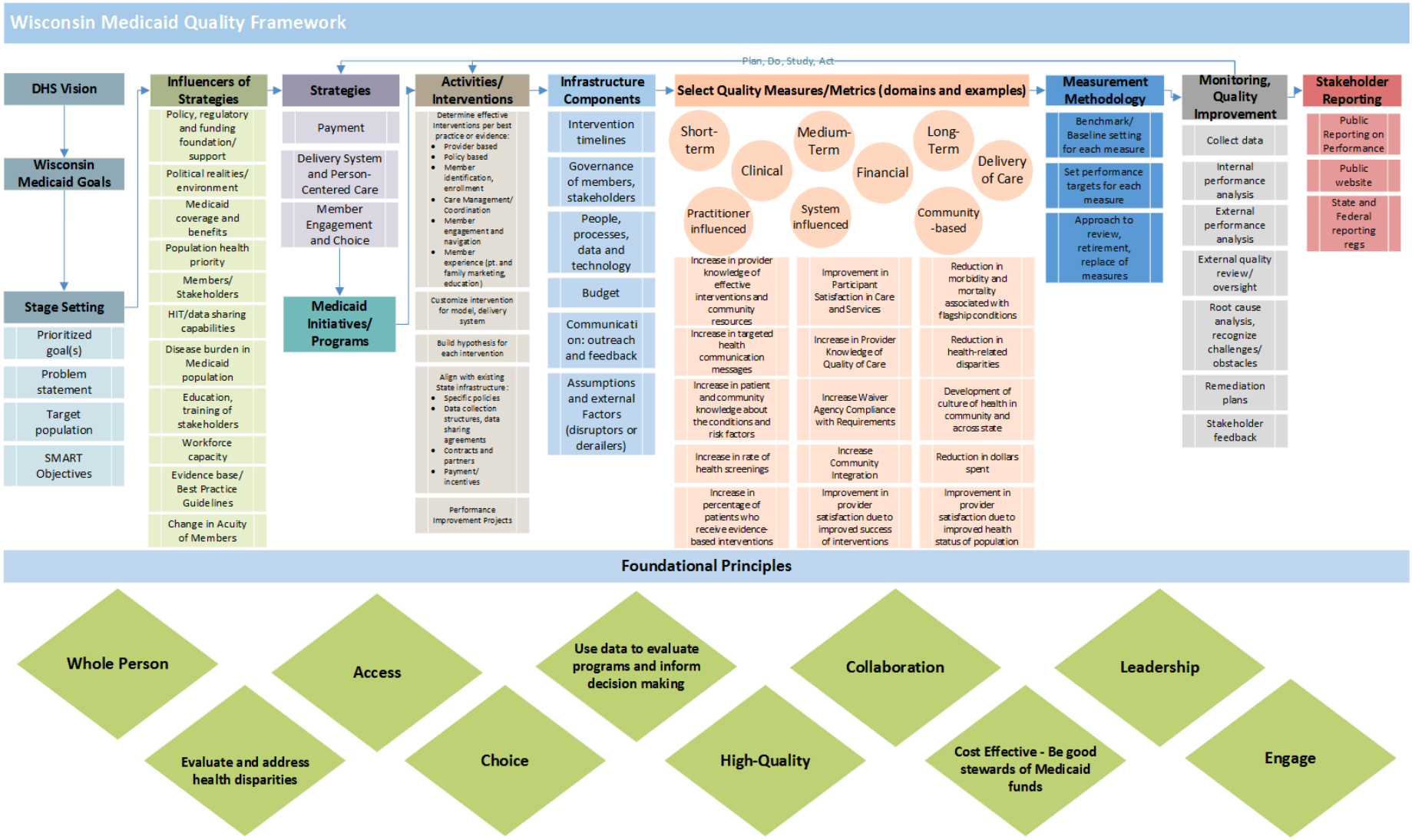
The quality framework includes 13 domains listed and described below:

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 measures selection:** Selection of measures aligned to interventions that cover varying areas (e.g. 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, measures, 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 in thinking through the implications of each area. This will inform decisions and provide a fully developed roadmap and planning effort. The foundational principles across the bottom of the quality framework should 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
Plan, Do, Study, Act
DHS Vision
Wisconsin Medicaid Goals
Stage Setting
Prioritized goal(s)
Problem statement
Target population
SMART Objectives
Influencers of Strategies
Policy, regulatory and funding foundation/ support
Political realities/ environment
Medicaid coverage and benefits
Population health priority
Members/ Stakeholders
HIT/data sharing capabilities
Disease burden in Medicaid population
Education, training of stakeholders
Workforce capacity
Evidence base/ Best Practice Guidelines
Change in Acuity of Members
Strategies
Payment
Delivery System and Person-Centered Care
Member Engagement and Choice
Medicaid Initiatives/ Programs
Activities/ Interventions
Determine effective Interventions per best practice or evidence:
Provider based
Policy based
Member identification, enrollment
Care Management/ Coordination
Member engagement and navigation
Member experience (pt. and family marketing, education)
Customize intervention for model, delivery system
Build hypothesis for each intervention
Align with existing State infrastructure:
Specific policies
Data collection structures, data sharing agreements
Contracts and partners
Payment/ incentives
Performance Improvement Projects
Infrastructure Components
Intervention timelines
Governance of members, stakeholders
People, processes, data and technology
Budget
Communicati on: outreach and feedback
Assumptions and external Factors (disruptors or derailers)
Select Quality Measures/Metrics (domains and examples)
Short-term
Medium-Term
Long-Term
Clinical
Financial
Delivery of Care
Practitioner influenced
System influenced
Community -based
Increase in provider knowledge of effective interventions and community resources
Increase in targeted health communication messages
Increase in patient and community knowledge about the conditions and risk factors
Increase in rate of health screenings
Increase in percentage of patients who receive evidence-based interventions
Improvement in Participant Satisfaction in Care and Services
Increase in Provider Knowledge of Quality of Care
Increase Waiver Agency Compliance with Requirements
Increase Community Integration
Improvement in provider satisfaction due to improved success of interventions
Reduction in morbidity and mortality associated with flagship conditions
Reduction in health-related disparities
Development of culture of health in community and across state
Reduction in dollars spent
Improvement in provider satisfaction due to improved health status of population
Measurement Methodology
Benchmark/ Baseline setting for each measure
Set performance targets for each measure
Approach to review, retirement, replace of measures
Monitoring, Quality Improvement
Collect data
Internal performance analysis
External performance analysis
External quality review/ oversight
Root cause analysis, recognize challenges/ obstacles
Remediation plans
Stakeholder feedback
Stakeholder Reporting
Public Reporting on Performance
Public website
State and Federal reporting regs
Foundational Principles
Whole Person
Access
Use data to evaluate programs and inform decision making
Collaboration
Leadership
Evaluate and address health disparities
Choice
High-Quality
Cost Effective - Be good stewards of Medicaid funds
Engage

b. Glossary

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.

Disability Status: For the purposes of non-discrimination and/or identifying and addressing health disparities based on disability status, DMS uses the following definitions by program:

- BadgerCare Plus and Medicaid SSI HMOs: the current contract defines "disability status" as whether the individual qualified for Medicaid on the basis of a disability.
- Long-term Care PIHPs: The LTC contracts developmental and physical disabilities as follows:
    - **Developmental Disability:** a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome. This also includes an intellectual disability diagnosed before age 18 and characterized by below-average general intellectual function and a lack of skills necessary for daily living, or another neurological condition closely related to such intellectual disability or requiring treatment similar to that required for such intellectual disability, that has continued or can be expected to continue indefinitely and

constitutes a substantial handicap to the afflicted individual. "Developmental disability" does not include senility that is primarily caused by the process of aging or the infirmities of aging.

- **Physical Disability:** a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person. In the context of physical disability, "major life activity" means self-care, performance of manual tasks unrelated to gainful employment, walking, receptive and expressive language, breathing, working, participating in educational programs, mobility other than walking and capacity for independent living.

- Children's PIHPs: For Children Come First and Wraparound Milwaukee, it includes all members with a severe emotional disturbance, as defined in the current contract. For Care4Kids, it means whether the individual qualified for Medicaid on the basis of a disability.

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, measures, 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, political, 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 (i.e. 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.

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 an insurer offers comprehensive health care services delivered by providers. These providers may be

both employees and partners of the HMO, or they may have entered into a referral or contractual agreement with the HMO for the purpose of providing contract-related services for enrolled members. 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 (i.e.: 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 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/Prepaid Inpatient Health Plan (PIHP): Each PIHP 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 PIHP refers to the

activities performed by long-term care managed care plans. PIHPs 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 of an individual 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 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 topics can be chosen by the HMO or PIHP, 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(s): 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 and assisted living communities while involving all nursing home and assisted living community 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 Managed Care 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:

- Prenatal and Post-partum care (PPC)
- Childhood immunization status (CIS)
- Immunizations for adolescents (IMA)
- Lead screening in children (LSC)
- Controlling blood pressure (CBP)
- Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET)
- Follow-up after emergency department visit for mental illness (30 days) (FUM)
- Follow-up after emergency department visit for alcohol and other drug abuse or dependence (30 days) (FUA)
- Follow-up after hospitalization for mental illness (30 days) (FUH)

Core reporting measures for BadgerCare Plus HMOs:

- Breast cancer screening (BCS-AD)
- Cervical cancer screening (CCS-AD)
- Chlamydia screening, ages 21-24 (CHL-AD)
- Controlling high blood pressure (CBP-AD)
- Comprehensive diabetes care: Hemoglobin A1c (HbA1c) poor control (>9.0%) (HPC-AD; this label is used by CMS in the 2020 Medicaid Adult Core Set)
- Plan all-cause readmissions (PCR-AD)
- Asthma medication ratio, ages 19-64 (AMR-AD)
- Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET-AD)
- Antidepressant medication management (AMM-AD)
- Follow-up after hospitalization for mental illness, age 18 and older (FUH-AD)
- Diabetes screening for people with schizophrenia or bipolar disorder, using antipsychotics (SSD-AD)
- Follow-up after ED visit for alcohol and other drug abuse or dependence (FUA-AD)
- Follow-up after ED visit for mental illness (FUM-AD)
- Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD)
- Prenatal and Postpartum Care: Postpartum Care (PPC-AD)
- Adolescent immunization (IMA-CH) – all except combo 2
- Childhood immunization status (CIS-CH) – all except combo 3
- Weight assessment and counseling (WCC-CH)
- Chlamydia screening, ages 16-20(CHL-CH)
- Asthma Medication Ratio (AMR-CH)
- Ambulatory care: ED visits (AMB-CH)

- Follow-up care for children prescribed attention deficit / hyperactivity disorder (ADHD) medication (ADD-CH)
- Follow-up after hospitalization for mental illness, ages 6-17 (FUH-CH)
- Metabolic monitoring for children and adolescents on antipsychotics (APM-CH)
- Use of first-line psychosocial care for children / adolescents on antipsychotics (APP-CH)
- Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)

Core Reporting Measures for SSI HMOs:

- Breast cancer screening (BCS-AD)
- Cervical cancer screening (CCS-AD)
- Chlamydia screening, ages 21-24 (CHL-AD)
- Controlling high blood pressure (CBP-AD)
- Comprehensive diabetes care: Hemoglobin A1c (HbA1c) poor control (>9.0%) (HPC-AD)
- Plan all-cause readmissions (PCR-AD)
- Asthma medication ratio, ages 19-64 (AMR-AD)
- Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET-AD) – initiation only
- Antidepressant medication management (AMM-AD)
- Follow-up after hospitalization for mental illness, age 18 and older (FUH-AD) – 7 days only
- Diabetes screening for people with schizophrenia or bipolar disorder, using antipsychotics (SSD-AD)
- Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD)

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.

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

Care4Kids Measures:

- Timely Out of Home Care Health Screen
- Timely Comprehensive Initial Health Assessment
- Timely Developmental and/or Mental Health Screen
- Timely Developmental Assessment
- Timely Mental Health Assessment
- Timely Comprehensive Health Care Plan
- HealthCheck periodicity
- Timely Comprehensive Dental Exam
- Blood Lead Testing
- Immunization Status
- Outpatient Mental Health Follow Up
- Emergency Department Utilization
- Inpatient Hospital Utilization
- Anti-Psychotic medication measures
- Psychotropic medication measure

ii. Long-Term Care

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

The following is a brief description of data sources and groups of performance indicators for which DMS monitors for improvement. These data sources can be understood as performance measurement tools at the compliance, process, outcome, and experience of care levels. To find more information about these data, reports can be accessed on the DHS website, linked in section 8.g. of the Appendices. The DHS website link is referred to in the Appendices as "Long-Term Care Quality Reports"

EQRO Quality Compliance Review

a. Enrollee Rights and Protections
b. Quality Assessment and Performance Improvement
c. Grievance System

EQRO Care Management Review

a. Assessment
b. Care Planning
c. Service Coordination and Delivery
d. Member-Centered Focus

Wisconsin Long-Term Care Scorecard Report

a. Access
b. Choice of Settings and Provider
c. Quality of Life
d. Support for Family Caregivers and Other Natural Supports
e. Effective Transitions
f. Reform Initiatives

MCO Satisfaction Survey

a. Can you contact your care team when you need to?
b. How often do you get the help you need from your care team?
c. How clearly does your care team explain things to you?
d. How carefully does your care team listen to you?
e. How respectfully does your care team treat you?
f. How well did your care team explain the self-directed supports option to you?
g. How involved are you in making decisions about your care plan?
h. 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?
i. How much does your care plan include the things that are important to you?
j. Overall, how respectfully do the people who provide you with supports and services treat you?
k. How well do the supports and services you receive meet your needs?
l. Overall, how much do you like your PIHP?

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. Children Come First and Wraparound Milwaukee are developing necessary infrastructure to submit encounters in 2021.
- *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 HMOs receive monthly enrollment file data provided by DMS. 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 Medical Home providers 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 (HEDIS)-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. There is also a mobile application called MyAccess available to members for program information and enrollment convenience.
- *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 PIHPs.
- *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 **Managed Care 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 consumers to access 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 PIHPs have and maintain care coordination software to document care provided and to maintain the current member-centered plan. The software varies by PIHP.
- *PIHP management information system:* Each long-term care PIHP 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 PIHPs report data, as requested by DMS, through the information exchange system. In addition to encounter reporting, uses of this system include incident reporting, restrictive measures reporting, and competitive integrated employment 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.
- *Wisconsin Statewide Health Information Network (WISHIN):* Wisconsin's health information network that shares electronic health information securely between participating physicians, clinics, hospitals, pharmacies, clinical laboratories, PIHP and HMOs across the state.

e. Quality Strategy Public Comments

The draft Quality Strategy document will be made available April 26 through May 21, 2021 for comment by stakeholders and the public through a number of outreach efforts. These outreach efforts include presentation to advisory committees and councils, tribal consultation, publication on the DHS website, newspaper announcement, and GovD notice. Following the 30-day public comment period, all feedback will be reviewed and included in the final Quality Strategy publication. Appendix 8e will include a summary of comments received on the Quality Strategy. The final version of the Quality Strategy will be available on the DHS website.

Comments: A summary of comments will be included in this section of the Quality Strategy.

f. Accreditation Deeming Plan

The Accreditation Deeming Plan is the crosswalk between federal requirements, standards used by NCQA for accredited health plans, and DMS's HMO contract and certification application materials. BadgerCare Plus and Medicaid SSI HMOs who have been accredited by NCQA may be deemed as meeting certain federal requirements, rather than requiring additional oversight from DMS or the EQRO. Additionally, this crosswalk assists with the identification of gaps in the DMS or EQRO oversight process, and may lead to strengthened contract language, certification application questions, and/or other oversight activities.

Accreditation status of each BadgerCare Plus and Medicaid SSI HMO is on the Department's website for the public to access; however, the below table is included for the current accreditation status:

Health Plan	Medicaid Accredited?	Other Accreditation Products
ANTHEM BLUE CROSS BLUE SHIELD	Accredited by NCQA	Commercial
MYCHOICE WISCONSIN	None	
CHILDRENS COMM HEALTH PLAN	Accredited by NCQA	Commercial, Exchange
DEAN HEALTH PLAN INC	None	Commercial, Exchange
GROUP HEALTH COOP EAU CLAIRE	Accredited by Accreditation Association for Ambulatory Health Care, Inc.	Commercial by Accreditation Association for Ambulatory Health Care, Inc.
GROUP HEALTH COOP SOUTHCENTR	None	Commercial, Exchange
INDEPENDENT CARE (ICARE)	None	
MERCY CARE INSURANCE COMPANY	None	Commercial, Exchange
MHS HEALTH WISCONSIN	Accredited by NCQA	
MOLINA HEALTHCARE	Accredited by NCQA	Exchange
NETWORK HEALTH PLAN	None	Commercial, Exchange
QUARTZ	None	Commercial, Medicare, Exchange

SECURITY HEALTH PLAN OF WISC	Accredited by NCQA	Commercial, Medicare, Exchange
UNITEDHEALTHCARE COMMUNITY PLAN	Accredited by NCQA	Commercial, Medicare, Exchange

1. The current accreditation deeming plan can be found on the ForwardHealth website as a PDF here: https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/pdf/2019_2021_HMO_Accreditation_Deeming_Plan.pdf.spage.
2. The upcoming accreditation deeming crosswalk will be posted online as a PDF once finalized and a link will be included in the final Quality Strategy. The current draft does not yet include the crosswalk of any NCQA MED Module standards or the Multicultural Health Care Distinction standards. The current crosswalk draft is included below for public comment:

MCO Accreditation Crosswalk

This Accreditation Crosswalk was prepared by the Department of Health Services and its External Quality Review Organization, MetaStar, in order to demonstrate to the Centers for Medicare & Medicaid Services (CMS) how the National Committee for Quality Assurance (NCQA) accredited organizations are deemed and therefore do not require a review of their compliance with Medicaid Managed Care rules. As instructed by CMS, this crosswalk was developed as the first step in the Managed Care Organization (MCO) Accreditation Deeming Plan to compare NCQA accreditation requirements with the federal Managed Care requirements for Medicaid MCOs (42 Code of Federal Regulations (CFR) section 438) in order to determine if there are any gaps between both requirements. The Accreditation Deeming Plan on pages 1-5 outlines Wisconsin's plan to seek CMS' approval for its Accreditation Deeming Policy and the next steps to cover any gaps identified in the crosswalk. This crosswalk was prepared using the *2021 Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2021.

The NCQA names and acronyms used in the following tables are: Quality Management and Improvement (QI), Population Health Management (PHM), Network Management (NET), Utilization Management (UM), Credentialing and Recredentialing (CR), and Member Experience (ME).

NCQA offers an optional Medicaid (MED) accreditation module. The MED module is in addition to the general NCQA accreditation and may address some of the remaining gaps between the federal Managed Care requirements and NCQA accreditation standards. MED standards meeting gap elements of the CFR are noted below in teal. NCQA also offers and optional distinction in multicultural health care (MHC). The MHC requirements did not meet any gaps between NCQA and the federal Managed Care regulations, but the distinction does align with the State's overall Quality Strategy.

Attachment 2: 42 CFR 438 Managed Care - Subpart C

Enrollee Rights and Protections

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.100 (a) (1) and (2) a) *General rule.* The State must ensure that: (1) Each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in this section; and (2) Each MCO, PIHP, PAHP, PCCM and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contracted providers observe and protect those rights.	**2/2**	ME1 CR5 CR7	**Met** ME1 evaluates if an organization has a written policy that states its commitment to treating members in a manner that respects their rights, and its expectations of members' responsibilities. ME1 also requires verification of the distribution of member rights policies and procedures to practitioners.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article VII – Member Rights and Responsibilities states the MCO must have written policies guaranteeing each member's rights, and share those policies with staff and affiliated providers to be considered when providing services to members. Article VI-Marketing and Member Materials requires MCOs to implement and enforce all requirements regarding member outreach and marketing processes as outlined in the *Communication,*	**None**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				Outreach and Marketing Guide. Addendum II indicates the Standard Member Handbook is located in the guide. ***Communication, Outreach, and Marketing Guide*** The MCO Standard Member Handbook requirements and required language are located in the *Communication, Outreach, and Marketing Guide*. The guide requires MCOs to make members aware of their rights in the Member Handbook which shall be provided in hardcopy to new members within 10 days of final enrollment notification to the MCO.		

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438.100 (b) (1) and (2) *Specific rights*—(1) *Basic requirement.* The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (3) of this section. (2) An enrollee of an MCO, PIHP, PAHP, PCCM, or PCCM entity has the following rights: The right to— (i) Receive information in accordance with §438.10. (ii) Be treated with respect and with due consideration for his or her dignity and privacy. (iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in §438.10(g)(2)(ii)(A) and (B).) (iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.	**1/2** **Not Met:** 438.100(b)(2)(iv) and (v) **MED: 1/2** **Not Met:** 438.100(b)(2)(iv) and (v)	ME1 ME2 ME3 ME7 NET1 NET5 MED12	**Not Met** The NCQA standards do not fully address the following details found in 438.100: • The right to refuse treatment; and • The right to be free of restraint or seclusion. The MED standards affirm the rights of members to receive information in a manner appropriate to the enrollee's condition and ability to understand. However, the standards do not address a member's right to be free from restraint/seclusion or the right to refuse	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article VII – Member Rights and Responsibilities affirms enrollees of MCOs have specific rights including the right to refuse treatment and to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. Article V: Provider Network and Access Requirements states the MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating	**1/1** **2020 Certification Application:** Requires MCOs to submit policies and procedures to confirm member rights are disseminated to members, providers, etc. **1/1**	**None** **None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. (vi) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.			treatment. The standards do meet the format and availability of requirements of 438.10	on behalf of an enrollee who is his or her patient, for the following: a. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. b. Any information the enrollee needs in order to decide among all relevant treatment options. c. The risks, benefits, and consequences of treatment or non-treatment. d. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				Article V: Provider Network and Access Requirements, MCOs also send the provider directory to members when requested, which is available online. The provider directory has information on every provider in network, their specialty, address, hours of operation, languages spoken, etc. ***Communication, Outreach, and Marketing Guide*** Includes Standard Member Handbook Language for the BadgerCare Plus and Medicaid SSI populations and includes family planning information. The information about member rights is included in the Member Handbook which all		

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				MCOs are required to send to their membership upon enrollment. MCOs are required to make the Member Handbook available to members in different languages and formats.		
438.100 (b) (3) An enrollee of an MCO, PIHP, or PAHP, PCCM or PCCM entity has the right to be furnished health care services in accordance with §§438.206 through 438.210.	**1/1**	ME1 ME2 ME3 ME7 NET1 NET6	**Met** ME1-Member Rights ME2-Benefits and services included in, and excluded from, coverage ME3-Covered and Noncovered benefits	**2020-2021BadgerCare Plus and Medicaid SSI Contract:** Article VII-Member Rights and Responsibilities affirms enrollees of MCOs have specific rights. Article V-Provider Network and Access Requirements, states MCOs must send the provider directory to members when requested, which is available online. The provider directory has information on every provider in network,	**None**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				their specialty, address, languages spoken, etc. ***Communication, Outreach, and Marketing Guide*** MCOs must make members aware of their rights in the Member Handbook which shall be provided in hardcopy to new members within 10 days of final enrollment notification to the HMO. The MCO Standard Member Handbook requirements and required language are located in the *Communication, Outreach, and Marketing Guide*		
438.100 (c) The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP,	**0/1**	ME1 ME2 ME7 UM7 UM8 UM9	**Not Met** ME sections address the member's rights and responsibilities and their ability to file	**2020-2021BadgerCare Plus and Medicaid SSI Contract:** Article VII – Member Rights and	**1/1** **2020 Certification Application:**	**None**

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PAHP, PCCM or PCCM entity and its network providers or the State agency treat the enrollee.			appeals/complaints, but there is no mention of adverse treatment by the MCO due to the exercise of their rights. UM 7-9 also deal with member appeal rights.	Responsibilities affirms that enrollees of MCOs have specific rights including freedom for the enrollee to exercise his or her rights, and that exercise of those rights does not adversely affect the way the MCO and its network providers treat the enrollee. Addendum II indicates the Standard Member Handbook is located in the guide ***Communication, Outreach, and Marketing Guide*** The information about Member Rights is included in the Member Handbook which all MCOs are required to send in hardcopy to new members within 10 days of final enrollment notification to the MCO.	Requires MCOs to submit policies and procedures demonstrating members are free to exercise individual rights.	

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				MCOs are required to make the Member Handbook available to members in different languages and formats. If a member has an issue about rights not being respected, they can contact the MCO Member Advocate, the Enrollment Specialist, the BadgerCare Plus and Medicaid SSI Ombudsman, grieve to the Department, or contact the SSI External Advocate (if in SSI Managed Care). All of these resources and an explanation of the Member Grievances process are included in the Member Handbook. DHS monitors member grievance trends quarterly.		
438.102 (a) (a) *General rules.* (1) An MCO, PIHP, or PAHP may not prohibit, or	**2/5**	ME1	**Not Met** The NCQA guidance notes that the	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:**	**3/3**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following: (i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. (ii) Any information the enrollee needs to decide among all relevant treatment options. (iii) The risks, benefits, and consequences of treatment or non-treatment. (iv) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (2) Subject to the information requirements of paragraph (b) of this section, an MCO, PIHP, or PAHP that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service			organization must not have any policies restricting dialogue between practitioner and patient and affirms that it does not direct practitioners to restrict information about treatment options. It does not, however, specifically address the following elements of this requirement: • The advocacy role of the practitioner; • The self-administered alternative treatment; and • The right of the enrollee to refuse treatment	Article I, Definitions, Authorized Representative is an individual appointed by the member, including a power of attorney or estate representative, who may serve as an authorized representative with documented consent of the member. The role of the authorized representative primarily includes filing a grievance or appeal, and approving the member's care plan. Article V: Provider Network and Access Requirements states the MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her	**Certification Application:** The certification application does not address the member handbook. **Other:** The *Communication Outreach and Marketing Guide* requires all MCOs to receive DHS approval of written materials before dissemination.	

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because of the requirement in paragraph (a)(1) of this section is not required to do so if the MCO, PIHP, or PAHP objects to the service on moral or religious grounds.			and express preferences.	patient, for the following: a. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. b. Any information the enrollee needs in order to decide among all relevant treatment options. c. The risks, benefits, and consequences of treatment or non-treatment. d. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.		

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				Communication, Outreach, and Marketing Guide The Member Handbook includes language about an enrollee's right to participate in decisions, including the right to refuse treatment. Also includes that enrollees have the right to receive information on available treatment options and alternatives. MCOs are required to send a Member Handbook in hardcopy to new members within 10 days of final enrollment notification to the MCO.		

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438.102 (b) (b) *Information requirements: MCO, PIHP, and PAHP responsibility.* (1)(i) An MCO, PIHP, or PAHP that elects the option provided in paragraph (a)(2) of this section must furnish information about the services it does not cover as follows: (A) To the State— (*1*) With its application for a Medicaid contract. (*2*) Whenever it adopts the policy during the term of the contract. (B) Consistent with the provisions of § 438.10, to enrollees, within 90 days after adopting the policy for any particular service. (ii) Although this timeframe would be sufficient to entitle the MCO, PIHP, or PAHP to the option provided in paragraph (a)(2) of this section, the overriding rule in § 438.10(g)(4) requires the State, its contracted representative, or MCO, PIHP, or PAHP to furnish the information at least 30 days before the effective date of the policy.	**0/2** **MED: 1/2** **Not Met:** 538.102(b)(1)	ME1 MED8	**Not Met** No element in the NCQA standards addresses this elected option and related communication requirements. The MED standards address the communication to members to access the service excluded by the MCO under moral or religious objection.	**2020-2021BadgerCare Plus and Medicaid SSI Contract:** Article IV-Services, MCOs are required to furnish information about the services it does not cover as follows: • To the Department and Enrollment Specialist so the Department can notify members of the MCO's non-coverage of service; • With the MCO's certification application for a BadgerCare Plus and/or Medicaid SSI contract; • Whenever the MCO adopts the policy during	**2/2** **2021 Certification Application:** The application requires the MCO to provide policies and procedures regarding moral or religious objections to care **1/2**	**None** **None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(2) As specified in § 438.10(g)(2)(ii)(A) and (B), the MCOs, PIHPs, and PAHPs must inform enrollees how they can obtain information from the State about how to access the service excluded under paragraph (a)(2) of this section.				the term of the contract; • It must be consistent with the provisions of 42 CFR 438.10; • It must be provided to potential members before and during enrollment; • It must be provided to members within ninety (90) days after adopting the policy with respect to any particular service; and • In written and prominent manner, the MCO shall inform members via their website		

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				and member handbook of any benefits to which the member may be entitled under BadgerCare Plus and Medicaid SSI but which are not available through the MCO because of an objection on moral or religious grounds. The MCO must inform members about hot to access those services through the State. Article II Enrollment and Disenrollment states a member may also request disenrollment if an HMO does not,		

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				because of moral or religious objections, cover the service the member seeks. The HMO must notify the Department, at the time of certification, of any services that they would not provide due to moral or religious objections. All MCOs provide information to members about covered services through the Member Handbook		
438.102 (c) (c) *Information requirements: State responsibility.* For each service excluded by an MCO, PIHP, or PAHP under paragraph (a)(2) of this section, the State must provide information on how and where to obtain the service, as specified in §438.10.	**0/0**	None	**Not Applicable, state responsibility**	**N/A**	**N/A**	**N/A**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.102 (d) (d) *Sanction.* An MCO that violates the prohibition of paragraph (a)(1) of this section is subject to intermediate sanctions under subpart I of this part.	**0/0**	None	**Not Applicable, state responsibility**	**N/A**	**N/A**	**N/A**
438.104 (a) *Definitions.* As used in this section, the following terms have the indicated meanings: *Cold-call marketing* means any unsolicited personal contact by the MCO, PIHP, PAHP, PCCM or PCCM entity with a potential enrollee for the purpose of marketing as defined in this paragraph (a). *Marketing* means any communication, from an MCO, PIHP, PAHP, PCCM or PCCM entity to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product, or either to not enroll in or to disenroll from another	**0/2** **Not Met:** 438.104(b)(1) and (2)	None	**Not Met** ME3 notes that NCQA does not review marketing materials if the MCO plan is government sponsored (Medicare/Medicaid).	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article VI-Marketing and Member Materials requires MCOs to implement and enforce all of the requirements regarding member outreach and marketing processes, including Title 42 Code as contained in the Communication Outreach and Marketing Guide ***Communication, Outreach, and Marketing Guide***	**2/2** **Certification Application:** The 2020 and 2021 Certification Applications do not monitor or review these requirements. **Other:** The *Communication Outreach and Marketing Guide* requires all MCOs to receive DHS approval of written materials before dissemination.	**None** All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan. *Marketing materials* means materials that— (i) Are produced in any medium, by or on behalf of an MCO, PIHP, PAHP, PCCM, or PCCM entity; and (ii) Can reasonably be interpreted as intended to market the MCO, PIHP, PAHP, PCCM, or PCCM entity to potential enrollees. *MCO, PIHP, PAHP, PCCM or PCCM entity* include any of the entity's employees, network providers, agents, or contractors. *Private insurance* does not include a qualified health plan, as defined in 45 CFR 155.20. (b) *Contract requirements.* Each contract with an MCO, PIHP, PAHP, PCCM, or PCCM entity must comply with the following requirements: (1) Provide that the entity—				The Health Plan agrees to engage only in member communication and outreach activities and distribute only those materials that are pre-approved in writing. The Health Plan that fails to abide by these requirements may be subject to sanctions.	This process confirms all elements are met.	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(i) Does not distribute any marketing materials without first obtaining State approval. (ii) Distributes the materials to its entire service area as indicated in the contract. (iii) Complies with the information requirements of §438.10 to ensure that, before enrolling, the beneficiary receives, from the entity or the State, the accurate oral and written information he or she needs to make an informed decision on whether to enroll. (iv) Does not seek to influence enrollment in conjunction with the sale or offering of any private insurance. (v) Does not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities. (2) Specify the methods by which the entity ensures the State agency that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the beneficiaries or the State agency. Statements that will be considered inaccurate, false, or						

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misleading include, but are not limited to, any assertion or statement (whether written or oral) that— (i) The beneficiary must enroll in the MCO, PIHP, PAHP, PCCM or PCCM entity to obtain benefits or to not lose benefits; or (ii) The MCO, PIHP, PAHP, PCCM or PCCM entity is endorsed by CMS, the Federal or State government, or similar entity. (c) *State agency review.* In reviewing the marketing materials submitted by the entity, the State must consult with the Medical Care Advisory Committee established under §431.12 of this chapter or an advisory committee with similar membership.						
438.106 Each MCO, PIHP, and PAHP must provide that its Medicaid enrollees are not held liable for any of the following: (a) The MCO's, PIHP's, or PAHP's debts, in the event of the entity's insolvency.	**0/5**	None	**Not Met** While NCQA standard ME5 references information about financial responsibility for pharmaceutical benefits, the relevance to these	**2020-2021BadgerCare Plus and Medicaid SSI Contract:** Article XVII-MCO Specific Contract Terms, The MCO agrees to defend, indemnify and hold the Department harmless with respect	**5/5** **2020 Certification Application:** The MCOs must submit attestations confirming	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(b) Covered services provided to the enrollee, for which— (1) The State does not pay the MCO, PIHP, or PAHP; or (2) The State, or the MCO, PIHP, or PAHP does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement. (c) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO, PIHP, or that those payments are in excess of the amount that the enrollee would owe if the MCO, PIHP, or PAHP covered the services directly.			requirements is limited. ME6 also contains language related to the organization's responsibility for considering members' financial responsibility, but as above, the specific details do not align with requirements.	to any and all claims, costs, damages and expenses, including reasonable attorney's fees that are related to or arise out of: a. Any failure, inability, or refusal of the MCO or any of its subcontractors to provide contract services. b. The negligent provision of contract services by the MCO or any of its subcontractors. c. Any failure, inability or refusal of the MCO to pay any of its subcontractors for contract services.	members are not held financially liable for the expenses outlined in this requirement.	
438.116 (a) *Requirement for assurances.* (1) Each MCO, PIHP, and PAHP that is not a Federally qualified	**0/1** **Not Met:** 438.116	None	**Not Met** While NCQA standard, ME5, references	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:**	**1/1** **2020 Certification**	**None**

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MCO (as defined in section 1310 of the Public Health Service Act) must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the MCO's, PIHP's, or PAHP's debts if the entity becomes insolvent. (2) Federally qualified HMOs, as defined in section 1310 of the Public Health Service Act, are exempt from this requirement. (b) *Other requirements*—(1) *General rule.* Except as provided in paragraph (b)(2) of this section, an MCO or PIHP, must meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity. (2) *Exception.* Paragraph (b)(1) of this section does not apply to an MCO or PIHP that meets any of the following conditions: (i) Does not provide both inpatient hospital services and physician services.			information about financial responsibility for pharmaceutical benefits, the relevance to these requirements is limited. ME6 also contains language related to the organization's responsibility for considering members' financial responsibility, but as above, the specific details do not align with requirements.	Article XVII-MCO Specific Contract Terms, The MCO agrees to defend, indemnify and hold the Department harmless with respect to any and all claims, costs, damages and expenses, including reasonable attorney's fees that are related to or arise out of: a. Any failure, inability, or refusal of the MCO or any of its subcontractors to provide contract services. b. The negligent provision of contract services by the MCO or any of its subcontractors. c. Any failure, inability or refusal of the MCO to pay any of its	**Application:** The MCOs must submit attestations confirming solvency standards are met and Medicaid enrollees are not held liable for debts due to the MCO's insolvency.	

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(ii) Is a public entity. (iii) Is (or is controlled by) one or more Federally qualified health centers and meets the solvency standards established by the State for those centers. (iv) Has its solvency guaranteed by the State.				subcontractors for contract services. Article XV- Fiscal Components/Provisions, states any provider who knowingly and willfully bills a BadgerCare Plus or Medicaid SSI member for a covered service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B.(d)(1) [42 U.S.C. 1320a-7b] of the Social Security Act and Wis. Stats. 49.49(3p). This provision shall continue to be in effect even if the MCO becomes insolvent. The MCO and its providers and subcontractors must not bill a BadgerCare Plus or Medicaid SSI member for medically		

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				necessary covered services provided to the member, for which the State does not pay the MCO; or the State or the MCO does not pay the individual or health care provider that furnished the services under contract, referral, or other arrangement; during the member's period of MCO enrollment, except for allowable copayments and premiums established by the Department for covered services provided during the member's period of enrollment in BadgerCare Plus. In addition, the MCO must ensure that its Medicaid members are not held liable for payments for medically necessary covered services furnished		

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				under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the MCO covered the services directly.		
438.108 **Cost Sharing** The contract must provide that any cost sharing imposed on Medicaid enrollees is in accordance with §§ 447.50 through 447.82 of this chapter.	**0/1** **Not Met:** 438.108	None	**Not Met** NCQA standards do not reflect the details included this requirement.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Addendum V-Benefits and Cost Sharing refers to the ForwardHealth Online Handbooks, Provider Updates, and interchange for the most recent information regarding covered services and allowable cost-sharing. Addendum II- Standard Member Handbook Language for BadgerCare Plus and Medicaid SSI requires	**0/1** **2020 and 2021 Certification Application:** The 2020 and 2021 Certification Applications do not monitor or review these requirements.	**1** All elements are addressed in the 2020-2021 contract, but are not included in the current certification process.

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				the MCO to notify members of any copays in the Member Handbook. Article XV- Fiscal Components/Provisions, states the MCO and its providers and subcontractors must not bill a BadgerCare Plus or Medicaid SSI member for medically necessary covered services provided to the member, for which the State does not pay the MCO; or the State or the MCO does not pay the individual or health care provider that furnished the services under contract, referral, or other arrangement; during the member's period of MCO enrollment, except for allowable copayments and premiums established by the		

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				Department for covered services provided during the member's period of enrollment in BadgerCare Plus.		
438.114 (a) *Definitions.* As used in this section— *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. (ii) Serious impairment to bodily functions. (iii) Serious dysfunction of any bodily organ or part.	**0/7** **MED: 5/7** **Not Met:** 438.114 (c),(d)(2)	None MED9	**Not Met** NCQA standards do not reflect the details included this requirement. The MED standards do not specifically note the limitation on holding the enrollee liable. Per NCQA, the organization will meet this element if its policies and	**2020-2021BadgerCare Plus and Medicaid SSI Contract:** Article IV-Services establishes that the MCO is responsible for coverage and payment of emergency and post-stabilization care. It also defines emergency, post-stabilization, and it addresses all the elements outlined in 438.114.	**7/7** **2021 Certification Application:** The application requires the MCO to provide policies and procedures regarding implementation of these requirements. **2/2**	**None** **NONE**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
Emergency services means covered inpatient and outpatient services that are as follows: (i) Furnished by a provider that is qualified to furnish these services under this Title. (ii) Needed to evaluate or stabilize an emergency medical condition. *Poststabilization care services* means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition. (b) *Coverage and payment: General rule.* The following entities are responsible for coverage and payment of emergency services and poststabilization care services. (1) The MCO, PIHP, or PAHP. (2) The State, for managed care programs that contract with PCCMs or PCCM entities (c) *Coverage and payment: Emergency services.* (1) The			procedures state that it covers all Emergency Department (ER) claims or does not deny any ER claims. The standard addresses when a representative of the MCO entity instructs the enrollee to seek emergency services and screening enrollee for need for emergency services. Post-stabilization services are addressed.			

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
entities identified in paragraph (b) of this section— (i) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP, PCCM or PCCM entity; and (ii) May not deny payment for treatment obtained under either of the following circumstances: (A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in paragraph (a) of this section. (B) A representative of the MCO, PIHP, PAHP, PCCM, or PCCM entity instructs the enrollee to seek emergency services. (2) A PCCM or PCCM entity must allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
enrollee to the provider that furnishes the services. (d) *Additional rules for emergency services.* (1) The entities specified in paragraph (b) of this section may not— (i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms; and (ii) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services. (2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. (3) The attending emergency physician, or the provider actually						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment. (e) *Coverage and payment: Poststabilization care services.* Poststabilization care services are covered and paid for in accordance with provisions set forth at §422.113(c) of this chapter. In applying those provisions, reference to "MA organization" and "financially responsible" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section, and payment rules governed by Title XIX of the Act and the States. (f) *Applicability to PIHPs and PAHPs.* To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the						

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
PIHP or PAHP is responsible, the rules under this section apply.						

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Access Standards

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.206 (a) (b) and 438.68 438.206 (a) *Basic rule.* Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that MCO, PIHP and PAHP provider networks for services covered under the contract meet the standards developed by the State in accordance with §438.68. (b) *Delivery network.* The State must ensure, through its contracts, that each MCO, PIHP and PAHP, consistent with the scope of its contracted services, meets the following requirements: (1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to	**2/4** **Not Met:** 438.68 (b) (1) (vii) 438.68 (c) (1) (iii), (iv) and (viii) 438.68 (b) (2) and (c) (2) are N/A and were not included in the total elements.	QI2 NET1 NET2 NET3 CR5 CR7	**Not Met** QI2 reviews the organization's contracts to ensure providers foster open communication and cooperation with QI activities. The organization may use its provider manual or	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article V. Provider Network and Access Requirements mandate that MCOs must provide medical care to its BadgerCare Plus and/or Medicaid SSI members that are accessible to them, in terms of timeliness, amount, duration, and scope, as those services to non-enrolled BadgerCare Plus and/or Medicaid SSI members within the area served by the MCO.	**1/2** **2021 Certification Application:** Each MCO must provide copies of the policies and procedures in place describing the process to ensure the provider network meets distance and drive time	**1** 438.68(c) (1) (viii) This is included in the contract, but MCO policies and procedures related to physical access to providers

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities. 438.68 (a) *General rule.* A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards consistent with this section. (b) *Provider-specific network adequacy standard.* (1) *Provider Types.* At a minimum, a State must develop a quantitative network adequacy standard for the following provider types, if covered under the contract: (i) Primary care, adult and pediatric. (ii) OB/GYN. (iii) Behavioral health (mental health and substance use disorder), adult and pediatric. (iv) Specialist (as designated by the State), adult and pediatric. (v) Hospital. (vi) Pharmacy. (vii) Pediatric dental. (2) *LTSS.* States with MCO, PIHP or PAHP contracts which cover LTSS must develop a quantitative network adequacy standard for LTSS provider types.			policies as evidence of contract requirements if the practitioner contract specifies that the manual or policy is an extension of the contract, and practitioners must abide by the conditions set forth in the contract and in the manual or policy. Some requirements may be met, but would require specific knowledge		requirements for primary care, mental health and substance abuse, dental care, hospitals, OB/GYN, and urgent care centers/walk-in clinics, and how the MCO monitors and addresses deficiencies. Policies and procedures describing the process to ensure the provider network meets the standards for primary care, dental care, and access to psychiatry,	and reasonable accommodations are not confirmed in the Certification Application

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(i) Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services; and (ii) Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services. (3) *Scope of network adequacy standards.* Network standards established in accordance with paragraphs (b)(1) and (2) of this section must include all geographic areas covered by the managed care program or, if applicable, the contract between the State and the MCO, PIHP or PAHP. States are permitted to have varying standards for the same provider type based on geographic areas. (c) *Development of network adequacy standards.* (1) States developing network adequacy standards consistent with paragraph (b)(1) of this section must consider, at a minimum, the following elements: (i) The anticipated Medicaid enrollment. (ii) The expected utilization of services. (iii) The characteristics and health care needs of specific Medicaid populations covered in the MCO, PIHP, and PAHP contract. (iv) The numbers and types (in terms of training, experience, and specialization) of			of what NCQA reviewed for a particular MCO. NET1, CR5, CR7 address maintenance and monitoring of the provider network, though are not specific about confirming that the network is supported by written agreements. Number and availability standards documented in NET1 do		including the plan to monitor compliance with these standards and how the MCO corrects for deficiencies if these ratios are not met must also be submitted. DHS conducts network reviews whenever an MCO requests changes to their service area. At a minimum, DHS reviews networks of all MCOs as part of the annual certification application.	

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
network providers required to furnish the contracted Medicaid services. (v) The numbers of network providers who are not accepting new Medicaid patients. (vi) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees. (vii) The ability of network providers to communicate with limited English proficient enrollees in their preferred language. (viii) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities. (ix) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions. (2) States developing standards consistent with paragraph (b)(2) of this section must consider the following: (i) All elements in paragraphs (c)(1)(i) through (ix) of this section. (ii) Elements that would support an enrollee's choice of provider.	**MED: 0/4** **Not Met:** 438.68 (b) (1) (vii) 438.68 (c) (1) (iii), (iv) and (viii)	MED3	not align with DHS expectations, which are greater than NCQA. NET2 also addresses accessibility and evaluates organizations based on the organizations' self-declared standards for accessibility (i.e. time to secure appointment). NCQA standards do not take into consideratio		As part of the network review, DHS reviews access to primary care, mental health and substance abuse, dental care, hospitals, urgent care or walk-in clinics, and OB/GYN providers. DHS makes sure that MCOs are providing needed care for members within acceptable geographic distance standards.	**1** 438.68(c) (1) (viii)

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(iii) Strategies that would ensure the health and welfare of the enrollee and support community integration of the enrollee. (iv) Other considerations that are in the best interest of the enrollees that need LTSS. (d) *Exceptions process.* (1) To the extent the State permits an exception to any of the provider-specific network standards developed under this section, the standard by which the exception will be evaluated and approved must be: (i) Specified in the MCO, PIHP or PAHP contract. (ii) Based, at a minimum, on the number of providers in that specialty practicing in the MCO, PIHP, or PAHP service area. (2) States that grant an exception in accordance with paragraph (d)(1) of this section to a MCO, PIHP or PAHP must monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report required under §438.66.			n the characteristics and health care needs of specific Medicaid populations. MED3 addresses the physical accessibility of providers, but does not address reasonable accommodations for Medicaid enrollees with physical or mental disabilities.		**1/2**	
438.206 (b) (2) (2) Provides female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and	**0/1**	None	**Not Met** NCQA does not review this element in its	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article V, Provider Network and Access Requirements requires	**1/1** **2021 Certification Application:**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	**MED: 1/1**	MED1	accreditation processes. MED 1 reviews MCO policies and procedures to assure female enrollees have direct access to a women's health specialist.	each MCO to provide female members with direct access to a women's health specialist within the network for covered women's routine and preventive health care services. This is in addition to a primary care provider. ***Communication Outreach and Marketing Guide***, Addendum I provides standard Member Handbook language to inform members of their right to see a women's health specialist without referral, in addition to choosing from their primary care physician.	The application requires MCOs to provide to the Department policies and procedures to make women's health specialists available to members and the waiting times for care. **NONE**	**NONE**
438.206 (b) (3) (4) (5) (3) Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network at no cost to the enrollee.	**0/3**	None	**Not Met** NCQA does not review this element in its	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article V, Provider Network and Access Requirements requires	**3/3** **2021 Certification Application:**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(4) If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover the services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP's provider network is unable to provide them. (5) Requires out-of-network providers to coordinate with the MCO, PIHP or PAHP for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.			accreditation processes.	that MCOs must have written policies and procedures for providing members the opportunity to have a second opinion. When a second opinion is outside of the network, it must be at no charge to the member, excluding allowable copayments. The MCO must also provide adequate and timely coverage of services provided out-of-network, when the required medical service is not available within the MCO network. ***Communication Outreach and Marketing Guide***, Addendum I provides standard Member Handbook language to inform members of their right to a second opinion.	The application requires MCOs to provide to the Department policies and procedures regarding provision of second medical opinions from a qualified provider in-network or out-of-network if needed. MCOs must also provide policies and procedures for providing members with referrals to out-of-network providers for services if the service is not available within the	

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
	MED: 3/3 **Not Met:** 438.68 (b) (1) (vii) 438.68 (c) (1) (iii), (iv) and (viii)	MED 1	MED 1 reviews MCO policies and procedures to ensure all requirements for second opinions and out-of-network providers are met.		MCO network, including information regarding coordination for payment and ensuring the cost to the member is no greater than it would be if the services were furnished within the network. **NONE**	**NONE**
438.206 (b) (6) (6) Demonstrates that its network providers are credentialed as required by §438.214.	**0/0**	None	**Not Applicable** See 438.214 in the Structure and Operations standards section of this appendix.	**N/A**	**N/A**	**N/A**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.206 (b) (7) Demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.	**0/1** **Not Met:** 438.206 (b) (7)	NET1 NET2 NET3	**Not Met** NCQA standards reference the accessibility of services and network adequacy as a whole, but do not specifically address the sufficiency of family planning providers.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Art. V, Provider Network and Access Requirements states the MCO must ensure its network includes sufficient family planning providers to ensure timely access to covered services. ***Communication Outreach and Marketing Guide***: The standard member handbook must include how members may obtain benefits, including family planning services and supplies from out-of-network providers, and include an explanation that the MCO cannot require a member to obtain a referral before choosing a family planning provider.	**0/1** **2021 Certification Application:** The 2021 Certification Application addresses adequacy of a network related to OB/GYN providers, and requires MCOs to provide policies and procedures to make women's health specialists available to members and the waiting times for care, but does not cover timely access specific to family	**1** 438.206(b) (7) This element is addressed in the 2020-2021 contract, but is not included in the current certification process.

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
					planning providers.	
438.206 (c) (1) (2) (3) (1) *Timely Access.* Each MCO, PIHP, AND PAHP must do the following: (i) Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees. (iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. (iv) Establish mechanisms to ensure compliance by network providers. (v) Monitor network providers regularly to determine compliance. (vi) Take corrective action if there is a failure to comply by a network provider. (2) *Access and cultural considerations.* Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and	**1/3** **Not Met:** 438.206(c)(1)(i), (ii), (iii), and (vi) 406.206(c)(3)	NET1 NET2 CR5 CR7	**Not Met** NCQA standards are not specific about the hours of operation and availability in the context of serving Medicaid enrollees. These standards also do not address the accessibility considerations required. NET 1 addresses assessment of network to ensure sufficient	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article V. Provider Network and Access Requirements and Article VII. Member Rights and Responsibilities The contract establishes that MCOs must have written standards for accessibility of care including specific waiting times for appointments. The contract also defines distance requirements for dental providers, primary care, mental health, substance abuse, OB/GYN providers, urgent care centers or walk-in clinics, and hospital access. MCOs are required to provide access to appropriate prenatal care services for high-risk pregnant women, women's health specialists, family planning services, medication-assisted	**1/2** **2021 Certification Application:** Sections 3. Service Area requires MCOs to submit policies and procedures to ensure the MCO's provider network meets the access standards in the contract. It also requires MCOs to submit their plans to monitor compliance with the standards and how the MCO corrects for	**1** 438.206(c) (3) *Accessibility considerations*. The contract requires MCOs to meet this standard, but the certification application does not specifically address monitoring provider complian

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
ethnic backgrounds, disabilities, and regardless of sex. (3) *Accessibility considerations*. Each MCO, PIHP, and PAHP must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	**MED: 1/3** **Not Met:** 438.206(c)(1)(i) and (3)	MED1 MED3	practitioners to meet language and cultural considerations. CR5 and CR7 address monitoring and assessment of providers. The MED standards cover hours of operation as well as accessibility considerations and monitoring of providers for compliance. The standards do not address	treatment (MAT) services, access to Indian Health providers, and to monitor network adequacy regularly, including whether network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.	deficiencies, if required ratios are not met. The process additionally requires submission of the MCO's plans for communicating standards to providers of primary, mental health, and dental care. **1/3**	ce with accessibility requirements. **1**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
			reasonable accommodations.			
438.207 (a) *Basic rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this part, including the standards at §438.68 and §438.206(c)(1). (b) *Nature of supporting documentation.* Each MCO, PIHP, and PAHP must submit documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: (1) Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area. (2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. (c) *Timing of documentation.* Each MCO, PIHP, and PAHP must submit the documentation	**0/3** **Not Met:** 438.207(a) (b) and (c) 438.207 (d) and (e) are NA and were not included in the total elements.	None	**Not Met** NCQA standards address network adequacy, but do not include provisions specific to the CFR requirements. Additionally, standards associated with network capacity/ accessibility do not align with DHS standards.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article V. Provider Network and Access Requirements state MCOs must provide assurances to the State that demonstrates the MCO has the capacity to serve the expected enrollment in its service area per the State standards for access to care. All MCO network reviews are based on the number of providers accepting new patients. The MCO must ensure its delivery network is sufficient to provide adequate access to all services covered under the contract. It also includes all considerations for the MCO in establishing the network. The MCO must provide documentation and assurance of the network adequacy criteria as	**3/3** **2021 Certification Application:** The application monitors network adequacy and collects the required documentation.	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
described in paragraph (b) of this section as specified by the State, but no less frequently than the following: (1) At the time it enters into a contract with the State. (2) On an annual basis. (3) At any time there has been a significant change (as defined by the State) in the MCO's, PIHP's, or PAHP's operations that would affect the adequacy of capacity and services, including— (i) Changes in MCO, PIHP, or PAHP services, benefits, geographic service area, composition of or payments to its provider network; or (ii) Enrollment of a new population in the MCO, PIHP, or PAHP. (d) *State review and certification to CMS.* After the State reviews the documentation submitted by the MCO, PIHP, or PAHP, the State must submit an assurance of compliance to CMS that the MCO, PIHP, or PAHP meets the State's requirements for availability of services, as set forth in §438.68 and §438.206. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for each contracted MCO, PIHP or PAHP related to its provider network.				required by the Department for pre-contract certification, annual provider network recertification, or upon request of the Department. The MCO must submit its provider network and facility file electronically in the format designed by the Department in the MCO Provider Network File Submission Specification Guide. The MCO must also notify the Department of changes related to network adequacy. Changes that could affect network adequacy have been defined by the Department as changes in the MCO's operations that would affect adequate capacity and services, including modifications to MCO benefits, geographic service areas, provider networks, payments, or enrollment of a new population into the MCO.		

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(e) *CMS' right to inspect documentation.* The State must make available to CMS, upon request, all documentation collected by the State from the MCO, PIHP, or PAHP.						
438.208 a) *Basic requirement*— (1) *General rule.* Except as specified in paragraphs (a)(2) and (3) of this section, the State must ensure through its contracts, that each MCO, PIHP, and PAHP complies with the requirements of this section. (2) *PIHP and PAHP exception.* For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of this section. (3) *Exception for MCOs that serve dually eligible enrollees.* (i) For each MCO that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare Advantage Organization (as defined in §422.2 of this chapter), the State determines to what extent the MCO must meet the identification, assessment, and treatment planning	**2/6** **Not Met:** 438.208 (b)(1), (b)(2)(iii), (b)(3), and (b)(4)	NET5 QI3 QI4	**Not Met** These standards address coordination and continuity of care; however, assurances for designating an entity with primary responsibility for coordination, except for those with complex conditions are not included in the guideline.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article III. Care Management requires MCOs to coordinate care between settings of care, with services provided by another MCO, with services a member receives through Medicaid Fee-for-Service, and with services a member receives through community and social support providers. Article VII. Member Rights and Responsibilities states MCOs must ensure that every member has a primary care provider or primary care clinic responsible for coordinating the services accessed by the member. The MCO must have a process in place to link each BadgerCare Plus and Medicaid SSI member with a primary care provider, a primary care clinic, or a specialist	**4/4** **2021 Certification Application:** The application requires MCOs to provide their primary care assignment policies and procedures to the Department for review which include a description of each requirement is met.	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
provisions of paragraph (c) of this section for dually eligible individuals. (ii) The State bases its determination on the needs of the population it requires the MCO to serve. (b) *Care and coordination of services for all MCO, PIHP, and PAHP enrollees.* Each MCO, PIHP, and PAHP must implement procedures to deliver care to and coordinate services for all MCO, PIHP, and PAHP enrollees. These procedures must meet State requirements and must do the following: (1) Ensure that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity; (2) Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee: (i) Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; (ii) With the services the enrollee receives from any other MCO, PIHP, or PAHP; (iii) With the services the enrollee receives in FFS Medicaid; and	**MED: 5/6** **Not Met:**	MED5 MED6	They also do not address the need to share assessment results to prevent duplication of activities. Privacy protections are addressed in 438.224 below. NET5 element B addresses continued access to a provider for active treatment/or for up to 90 days whichever is less if member has	when appropriate based on the preferences and health care needs of the member. The process shall include a defined method to notify the member of their primary care provider and how to contact the provider. MCOs are required to have a system in place that ensures well-managed patient care, meeting all Federal requirements.		**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(iv) With the services the enrollee receives from community and social support providers. (3) Provide that the MCO, PIHP or PAHP makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful; (4) Share with the State or other MCOs, PIHPs, and PAHPs serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities; (5) Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and (6) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	438.208 (b)(2)(iii),		a chronic or acute condition. QI3 and QI4 address collecting information and identifying opportunities for improvement in coordination of care. MED standards address the requirement for an ongoing source of care, but does not address coordination of care with		**1/1**	

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
			services the enrollee receives in FFS Medicaid. The MED standards also address the completion and sharing of an initial screening.			
438.208 (c) (1) (c) *Additional services for enrollees with special health care needs or who need LTSS—* (1) *Identification.* The State must implement mechanisms to identify persons who need LTSS or persons with special health care needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms— (i) Must be specified in the State's quality strategy under §438.340. (ii) May use State staff, the State's enrollment broker, or the State's MCOs, PIHPs and PAHPs.	**0/0**	None	**Not applicable; State responsibility**	**N/A**	**N/A**	**N/A**
438.208 (c) (2) (3) (4) (2) *Assessment.* Each MCO, PIHP, and PAHP must implement mechanisms to	**2/2**	PHM4 QI3 QI4	**Met** The NCQA guidance	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:**	**None**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
comprehensively assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCO, PIHP, and PAHP by the State as needing LTSS or having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the MCO, PIHP, or PAHP as appropriate. (3) *Treatment/ service plans.* MCOs, PIHPs, or PAHPs must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(i) through (v) of this section for enrollees who require LTSS and, if the State requires, must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(iii) through (v) of this section for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be: (i) Developed by an individual meeting LTSS service coordination requirements with	(c)(3) is N/A and was not included in the total elements.		notes the look back period for this requirement is at least once during the prior year for first surveys and 24 months for renewals. The Medicaid product line is exempted if the state conducts its own assessment or mandates a tool for the MCO to conduct the assessment, but the MCO must provide proof of such	Article X – Quality Assessment Performance Improvement states the MCO must identify at-risk populations for preventive services and develop strategies for reaching BadgerCare Plus and/or Medicaid SSI members included in this population. MCOs are encouraged to develop and implement disease management programs and systems to enhance quality of care for individuals identified as having chronic or special health care needs known to be responsive to application of clinical practice guidelines and other techniques. The MCO agrees to implement systems to independently identify members with special health care needs and to utilize data generated by the systems or data that may be provided by the Department to facilitate outreach, assessment, and care for individuals with special health care needs.		

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
enrollee participation, and in consultation with any providers caring for the enrollee; (ii) Developed by a person trained in person-centered planning using a person-centered process and plan as defined in §441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans; (iii) Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO, PIHP, or PAHP; (iv) In accordance with any applicable State quality assurance and utilization review standards; and (v) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per §441.301(c)(3) of this chapter. (4) *Direct access to specialists.* For enrollees with special health care needs determined through an assessment (consistent with paragraph (c)(2) of this section) to need a course of treatment or regular care monitoring, each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.			a requirement. QI3 and QI4 focus on continuity and coordination of medical care and medical/behavioral health care.	Article III, requires MCOs to develop care management guidelines to operationalize their care management model, which must receive Department approval prior to implementation. The MCO must have policies and procedures in place to allow members with special health care needs to directly access a specialist as appropriate for the member's condition and identified needs. The contract also outlines the care management requirements for MCOs serving Medicaid SSI enrollees including timeframes and an evidence-based care plan. MCOs must conduct an initial screen for all BadgerCare Plus members to gather necessary information for care management.		

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.210 (a) (a) *Coverage.* Each contract between a State and an MCO, PIHP, or PAHP must do the following: (1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer. (2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in §440.230 of this chapter, and for enrollees under the age of 21, as set forth in subpart B of part 441 of this chapter. (3) Provide that the MCO, PIHP, or PAHP— (i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. (ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. (4) Permit an MCO, PIHP, or PAHP to place appropriate limits on a service— (i) On the basis of criteria applied under the State plan, such as medical necessity; or	**1/4** **Not Met:** 438.210 (a) (1), (2), (4) and (5)	UM1 UM2 UM3 UM4 UM5	**Not Met** NCQA UM standards address requirements in general, but NCQA does not specifically address this element. The NCQA guidance includes several standards related to UM that are similar to DHS standards or protocols, but may not meet DHS' responsibilities to ensure that the MCO is not	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** The contract defines the services that MCOs will cover in Article IV, Services. Medical necessity is defined in the contract as well as the standards of access to care that MCOs are accountable for.	**3/3** **2021 Certification Application:** The application requires submission of policies and procedures along with data files that address the MCO's ability to provide an adequate, appropriate network of providers. DHS also reviews care management policies, procedures, and guidelines related to the MCO care management	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(ii) For the purpose of utilization control, provided that— (A) The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section; (B) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and (C) Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20 of this chapter. (5) Specify what constitutes "medically necessary services" in a manner that— (i) Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and (ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services that address: (A) The prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or			limiting services required in the benefit package described in DHS MCO contract. For example, the NCQA criteria describes that it "takes into account the local delivery system." If NCQA considers the Medicaid contract as part of the "local delivery system" in making its evaluation of the MCO, then the		system and continuity of care to ensure member-specific care and coordination is provided.	

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
disorder that results in health impairments and/or disability. (B) The ability for an enrollee to achieve age-appropriate growth and development. (C) The ability for an enrollee to attain, maintain, or regain functional capacity. (D) The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.			element may be comparable. UM 5 is focused on timeliness of decisions and those timelines may not align exactly with DHS contract standards Another example relates to timeframe differences between DHS and NCQA standards: 14 days (DHS) vs 15 days (NCQA) for non-			

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
			urgent decisions.			
438.210 (b) (b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require— (1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures. (2) That the MCO, PIHP, or PAHP— (i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. (ii) Consult with the requesting provider for medical services when appropriate. (iii) Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan. (3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.	**3/3**	UM1 UM2 UM4 UM6	**Met** NCQA utilization management (UM) standards require each organization to have a UM program with a clearly defined structure and processes, with responsibility assigned to appropriate individuals. This includes participation of a senior-level physician	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article X- Quality Assessment Performance Improvement requires that the MCO and its subcontractors must have documented policies and procedures for all UM activities that involve determining medical necessity and processing requests for initial and continuing authorization of services. The MCO must communicate to providers the criteria used to determine medical necessity and appropriateness. The criteria for determining medical necessity may not be more stringent than what is used in the State Medicaid program. Documentation of denial of services must be available to the Department upon request.	**None**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
			and behavioral healthcare practitioner. UM decision making criteria are objective and based on medical evidence.	The MCO must also have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting provider for medical services when appropriate. When reviewing requests for authorization of services, qualified medical professionals must be involved in any decision-making that requires clinical judgment. The decision to deny, reduce or authorize a service that is less than requested must be made by a health professional with appropriate clinical expertise in treating the affected member's condition(s). The MCO may not deny coverage, penalize providers, or give incentives or payments to providers or members that are intended to reward inappropriate restrictions on care or results in the under-utilization of services.		

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.210 (c) (d) (c) *Notice of adverse benefit determination.* Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs, PIHPs, and PAHPs, the enrollee's notice must meet the requirements of §438.404. (d) *Timeframe for decisions.* Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices: (1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if— (i) The enrollee, or the provider, requests extension; or (ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. (2) *Expedited authorization decisions.*	**1/2** **Not Met:** 438.210 (d) 438.210 (d)(3) is NA as covered outpatient drug coverage is carved out of the DHS-MCO contract.	UM2 UM5 UM7	**Not Met** While timeframes for decision-making are addressed in these NCQA references, the details do not align with all timeframes associated with this requirement.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article X- Quality Assessment Performance Improvement states the MCO's policies must specify time frames for responding to requests for initial and continued service authorizations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited responses to requests for authorization of urgently needed services. The contract also specifies written notice requirements and allowable timeframes for authorization decisions.	**1/1** **2021 Certification Application:** The application requires submission of policies and procedures related to notification of adverse actions and timeliness of decisions including policies for processing expedited and urgent authorization requests.	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service. (ii) The MCO, PIHP, or PAHP may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. (3) *Covered outpatient drug decisions.* For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act.						
438.210 (e) (e) *Compensation for utilization management activities.* Each contract between a State and MCO, PIHP, or PAHP must provide that, consistent with §§438.3(i), and 422.208 of this chapter, compensation to individuals or entities that conduct utilization management	**1/1**	UM2 UM4	**Met** Standard UM2 requires MCOs to have written utilization	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article X- Quality Assessment Performance Improvement states the MCO may not deny coverage, penalize providers, or give	**None**	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.			management decision-making criteria that is objective and based on medical evidence. UM4 focuses on service denials being based upon medical necessity and no other criteria (other than the existence of coverage). It also includes an element that determines utilization management decisions are based on appropriateness of care	incentives or payments to providers or members that are intended to reward inappropriate restrictions on care or result in the under-utilization of services. Article XV. Fiscal Components/ Provisions, states MCOs may operate a physician incentive plan only if no specific payment can be made directly or indirectly under such a plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.		

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
			and financial incentives do not encourage decisions that result in under-utilization or reward practitioners for denials of service.			

Structure and Operations Standards

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.214 (a) and (b) (a) The state must ensure, through its contracts, that each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers and that those policies and procedures, at a minimum, meet the requirements of this section.	**0/2** **Not Met:** 438.214 (a) and (b)	CR1	**Not Met** CR1 requires MCOs to have well-defined credentialing and recredentiali	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article X. Quality Assessment Performance Improvement outlines the process MCOs must follow to credential and recredential providers.	**2/2** **2020 Certification Application:** The Application requires MCOs to submit	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(b) *Credentialing and recredentialing requirements.* (1) Each State must establish a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate, and requires each MCO, PIHP and PAHP to follow those policies. (2) Each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of network providers.			ng processes, though they do not specify adhering to a state's uniform credentialing and recredentialing policy.		policies and procedures related to the credentialing process for new and recertifying providers, including a description of all related process steps including the required database searches.	
438.214 (c) Nondiscrimination (c) *Nondiscrimination.* MCO, PIHP, and PAHP network provider selection policies and procedures, consistent with §438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	**0/1** **Not Met:** 438.214 (c)	CR1	**Not Met** CR1 includes language related to nondiscrimination but is not specific about providers serving high risk/high cost consumers.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article X- Quality Assessment Performance Improvement states the selection process must not discriminate against providers such as those serving high-risk populations, or specialize in conditions that require costly treatment. The MCO must have a process for receiving advice on the selection criteria for	**0/1** **2020 Certification Application:** The Application requires MCOs to submit policies and procedures related to the credentialing process for	**1** This element is addressed in the 2020-2021 contract, but not included in the

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
				credentialing and recredentialing practitioners in the MCO's network.	new and recertifying providers, including a description of all related process steps including the required database searches. The Certification Application does not address nondiscrimination in credentialing or recredentialing providers.	current certification process.
438.214 (d) (d) Excluded providers. (1) MCOs, PIHPs, and PAHPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.	**0/1**	CR3 CR5 CR7	**Not Met** MCOs are required to confirm credentialed providers are in good standing	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article X- Quality Assessment Performance Improvement prohibits an MCO from employing or contracting with providers debarred or excluded	**1/1** **2020 Certification Application:** The Application requires MCOs to submit	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
			with state and federal regulatory bodies. Collecting and reviewing information from the *List of Excluded Individuals and Entities* (maintained by OIG) is included as an option to identify any sanctions against providers. However, the standards do not review to confirm the MCO has a process that clearly prohibits	in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.	policies and procedures related to the credentialing process for new and recertifying providers, including a description of the verification that federally excluded providers are not part of the MCO's provider network.	

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
			excluded providers or employees.			
438.214 (e) (e) Each MCO, PIHP, and PAHP must comply with any additional requirements established by the State.	**0/1**	None	**Not Met** NCQA standards do not address this requirement.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article XI., MCO Administration addresses compliance with all federal and state statutes. The contract also requires memoranda of understanding (MOU) to coordinate services with Prenatal Care Coordination (PNCC) agencies, school-based services, local law enforcement agencies for transfer to emergency detention or commitment, human service agencies in the counties within the MCO service area to coordinate Fee-for-Service services, hub and spoke pilot sites to coordinate AIDS services, and home health agencies to prevent duplication of services. In addition, the MCO must work with the, Targeted Case Management Services, as indicated in Addendum III.	**1/1** **2020 Certification Application:** The Application requires MCOs to submit a list of all subcontractors and organizations with which there is a MOU/ agreement/ contract currently in effect.	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.224 **Confidentiality** The State must ensure, through its contracts, that (consistent with subpart F of part 431 of this chapter), for medical records and any other health and enrollment information that identifies a particular enrollee, each MCO, PIHP, and PAHP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.	**0/1** **Not Met:** 438.224 **MED: 1/1**	None MED4	NCQA does not review this element in its accreditation processes. The MED standards address the confidentiality of member information and records.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article XI MCO Administration defines appropriate disclosure of individually identifiable health information. It also describes inappropriate disclosures of individually identifiable health information and sets liquidated damages in case of breaches.	**0/1** **2020 and 2021 Certification Application:** The Certification process does not address or monitor confidentiality requirements. **NONE**	**1** This element is addressed in the 2020-2021 contract, but not included in the current certification process. **NONE**
438.228 **Grievance and appeal systems** (a) The State must ensure, through its contracts that each MCO, PIHP, and PAHP has in effect a grievance and appeal system that	**0/0**	None	**See Subpart F, Grievance Systems for details related to**	**N/A**	**N/A**	**N/A**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
meets the requirements of subpart F of this part. (b) If the State delegates to the MCO, PIHP, or PAHP responsibility for notice of action under subpart E of part 431 of this chapter, the State must conduct random reviews of each delegated MCO, PIHP, or PAHP and its providers and subcontractors to ensure that they are notifying enrollees in a timely manner.			**this requirement.**			
438.230 **Subcontractual relationships and delegation agreement** (a) *Applicability.* The requirements of this section apply to any contract or written arrangement that an MCO, PIHP, PAHP, or PCCM entity has with any subcontractor. (b) *General rule.* The State must ensure, through its contracts with MCOs, PIHPs, PAHPs, and PCCM entities that— (1) Notwithstanding any relationship(s) that the MCO, PIHP, PAHP, or PCCM entity may have with any subcontractor, the MCO, PIHP, PAHP, or PCCM entity maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State; and (2) All contracts or written arrangements between the MCO, PIHP, PAHP, or PCCM	**0/3** **Not Met:** 438.230 (a), (b), and (c)	QI5 PHM7 NET6 UM13 CR8 ME8	**Not Met** Each section of the NCQA standards includes delegation of all or part of the section. Up to four delegation agreements in effect during the look-back period are reviewed. However, the NCQA requirement	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article XI. MCO Administration requires all MCO subcontractors to be in compliance with federal and state statutes, including the specific requirements of this section.	**2/3** **2020 Certification Application:** The Application requires MCOs to submit a list of all subcontractors and organizations in which there is a MOU/ agreement/ contract currently in effect, and a copy of the	**1** All elements are addressed in the 2020-2021 contract, but 438.230(c)(3) is not included in the current certificat

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
entity and any subcontractor must meet the requirements of paragraph (c) of this section. (c) Each contract or written arrangement described in paragraph (b)(2) of this section must specify that: (1) If any of the MCO's, PIHP's, PAHP's, or PCCM entity's activities or obligations under its contract with the State are delegated to a subcontractor— (i) The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. (ii) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, PAHP's, or PCCM entity's contract obligations. (iii) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, PAHP, or PCCM entity determine that the subcontractor has not performed satisfactorily. (2) The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions; (3) The subcontractor agrees that—	**MED: 2/3** **Not Met:** 438.230 (c)	MED15	s for delegation agreements do not align with the requirements of the CFR. The NCQA MED standard requirements for delegation agreements aligns with most requirements of the CFR. The MED standards do not specifically		subcontractor contract template. The MCO must also submit policies and procedures for delegation that includes the requirements listed under 438.230(c) (1) and (2), but does not address 438.230(c)(3). **0/1**	ion process. **1**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(i) The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's, PIHP's, or PAHP's contract with the State. (ii) The subcontractor will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of this section, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees. (iii) The right to audit under paragraph (c)(3)(i) of this section will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. (iv) If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.			address subcontractor compliance with Medicaid laws, or regulations such as State or CMS having the right to audit.			

Measurement and Improvement Standards

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.236 (a) (b) (a) *Basic rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP meets the requirements of this section. (b) *Adoption of practice guidelines.* Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements: (1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field. (2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees. (3) Are adopted in consultation with contracting health care professionals. (4) Are reviewed and updated periodically as appropriate.	**0/4** **Not Met:** 438.236 (b) **MED: 4/4**	None MED2	**Not Met** Practice guidelines were eliminated as a NCQA standard beginning July 1, 2018. Population health management focuses on the whole person and each member's needs. This is too broad to cover the specific CFR requirements.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article X- Quality Assessment Performance Improvement requires MCOs to develop or adopt best practice guidelines in accordance with the requirements.	**4/4** **2021 Certification Application:** The Application requires submission of a description of the clinical guidelines used for utilization management, member education on health and disease management, coverage of services and other areas to which the guidelines may apply. Related policies and procedures used by MCOs are	**None** **None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
			The MED standards require adopting and updating clinical practice guidelines that are reviewed and updated at least every two years.		also required specific to adoption and review/update of guidelines. **None**	
438.236 (c) (c) *Dissemination of guidelines.* Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	**0/2** **Not Met:** 438.236 (c)	None MED2	**Not Met** NCQA eliminated practice guidelines as a standard beginning July 1, 2018.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article X- Quality Assessment Performance Improvement requires MCOs to disseminate established practice guidelines to providers and, upon request, to members and potential members.	**2/2** **2021 Certification Application:** The 2021 Certification Application includes the dissemination of guidelines to providers and members	**None** **None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
	MED: 2/2		The MED standards require dissemination of practice guidelines as required in CFR.		(upon request). **None**	
438.236 (d) (d) *Application of guidelines.* Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	**0/1** **Not Met:** 438.236 (d) **MED: 0/1** **Not Met:** 438.236 (d)	UM2 MED2	**Not Met** While the UM standards reflect the need to adhere to evidence-based criteria and local delivery system practice, NCQA eliminated practice guidelines as a standard beginning July 1, 2018. The MED standard only	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article X- Quality Assessment Performance Improvement states that decisions with respect to utilization management, member education, coverage of services, and other areas to which the guidelines apply must be consistent with the guidelines.	**1/1** **2021 Certification Application:** The Application reviews a description of the practice guidelines as well as the related policies and procedures used by MCOs. **1/1**	**None** **None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
			references the use of practice guidelines in member education, not for utilization, coverage or other areas.			
438.242 (a) (a) *General rule.* The State must ensure, through its contracts that each MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	**0/1** **Not Met:** 438.242 (a)	PHM2 UM2	**Not Met** NCQA standards for both PHM and UM focus on data collection from claims, encounters, electronic health records, or other data sources. However, there is no NCQA standard regarding an MCO maintaining a health information system that	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article XII- Reports and Data describes the requirements for MCOs to maintain their health information systems.	**1/1** **2021 Certification Application:** The Application requires MCOs to provide documentation confirming the organization has the security, data, claims and encounter processing, computer system and reporting standards as outlined in the contract and in	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
			can collect, analyze, integrate, and report data.		compliance with this standard. **Other:** DHS conducts encounter data testing with MCOs.	
438.242 (b) (b) *Basic elements of a health information system.* The State must require, at a minimum, that each MCO, PIHP, and PAHP comply with the following: (1) Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act. (2) Collect data on enrollee and provider characteristics as specified by the State, and on all services furnished to enrollees through an encounter data system or other methods as may be specified by the State.	**0/1** **Not Met:** 438.242 (b)	None	**Not Met** NCQA standards do not specify the basic elements needed for health information systems.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article XII Reports and Data Describes the requirements for MCOs to maintain their health information systems and submit compliant encounter data files.	**0/1** **2021 Certification Application:** The Application requires the MCOs to meet security, data, claims and encounter processing, computer system, and reporting standards outlined in the 2020-2021 BadgerCare Plus and Medicaid SSI	**1** 438.242(b)(5) and (6) This is a new requirement, effective 1/1/21 and was not included in the 2021 certification application. Recommend adding to the 2022 Certification Application to address this gap.

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(3) Ensure that data received from providers is accurate and complete by— (i) Verifying the accuracy and timeliness of reported data, including data from network providers the MCO, PIHP, or PAHP is compensating on the basis of capitation payments. (ii) Screening the data for completeness, logic, and consistency. (iii) Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts. (4) Make all collected data available to the State and upon request to CMS.(5) Implement an Application Programming Interface (API) as specified in 431.60 of this chapter as if such requirements applied directly to the MCO, PIHP, or PAHP and include— (i) All encounter data, including encounter data from any network providers the MCO, PIHP, or PAHP is compensating on the basis of capitation payments and adjudicated claims and encounter data from any subcontractor.					Contract. It also requires submission of policies and procedures in place to meet the outlined requirements.	

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(ii) [Reserved] (6) Implement, by January 1, 2021, and maintain a publicly accessible standards-based API described in 431.70, which must include all information specified in 438.10(h)(1) and (2) of this chapter.						
438.242 (c) (d) (c) *Enrollee encounter data.* Contracts between a State and a MCO, PIHP, or PAHP must provide for: (1) Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees. (2) Submission of enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs. (3) Submission of all enrollee encounter data, including allowed amount and paid amount, that the State is required to report to CMS under §438.818. (4) Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.	**0/1** **Not Met:** 438.242 (c) 438.242 (d) is N/A and was not included in the total elements.	None	**Not Met** NCQA standards focus on data collection and analytics in general, but do not address external reporting, submission, review, or validation of the data collected.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article XII Reports and Data describes the requirements for MCOs to maintain their health information systems.	**1/1** **2021 Certification Application:** requires the MCOs to meet security, data, claims and encounter processing, computer system, and reporting standards outlined in the 2020-2021 BadgerCare Plus and Medicaid SSI Contract. It also requires submission of	**None**

Federal Requirement	Elements Met with NCQA Accreditation/Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(d) *State review and validation of encounter data.* The State must review and validate that the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP, meets the requirements of this section. The State must have procedures and quality assurance protocols to ensure that enrollee encounter data submitted under paragraph (c) of this section is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP.					policies and procedures in place to meet the outlined requirements.	

42 CFR 438 Managed Care - Subpart E

Quality Measurement and Improvement Standards

The majority of Subpart E is applicable to states and EQROs. Those sections of CFR not applicable to MCOs, PHIPs or PAHPs were excluded.

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.330 (a) (b) (a) *General rules.* (1) The State must require, through its contracts, that each MCO, PIHP, and PAHP establish and implement an ongoing	**2/4** **Not Met:** 438.330 (b)(1) and (3)	QI1 QI3 QI4 PHM1 PHM6	**Not Met** The NCQA standards require a quality	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article X. Quality Assessment and Performance Improvement	**2/2** **2021 Certification Application:**	**None** DHS analysis

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees that includes the elements identified in paragraph (b) of this section. (2) After consulting with States and other stakeholders and providing public notice and opportunity to comment, CMS may specify performance measures and PIPs, which must be included in the standard measures identified and PIPs required by the State in accordance with paragraphs (c) and (d) of this section. A State may request an exemption from including the performance measures or PIPs established under paragraph (a)(2) of this section, by submitting a written request to CMS explaining the basis for such request. (3) The State must require, through its contracts, that each PCCM entity described in §438.310(c)(2) establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees which incorporates, at a minimum, paragraphs (b)(2) and (3) of this section and the performance measures identified by the State per paragraph (c) of this section. (b) *Basic elements of quality assessment and performance improvement programs.* The	438.330 (b)(5)(ii) is N/A and was not included in the total elements.		improvement infrastructure which includes an annual work plan and annual evaluation. The standards do not specifically require improvement projects and do not address monitoring for under- and over-utilization. QI3 and QI4 include coordination and continuity of care for both medical and behavioral	specifically addresses the requirements of the CFR elements. The QAPI is not monitored annually, but must be made available to the Department upon request.	The Application requires all MCOs to submit its accreditation status including lines of business or specific population for which accreditation was obtained, and the year of accreditation. The 2021 Certification Application does request the MCO's most recent Quality Assessment/Performance Improvement (QAPI) work	of encounter data could address element (b)(3).

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
comprehensive quality assessment and performance improvement program described in paragraph (a) of this section must include at least the following elements: (1) Performance improvement projects in accordance with paragraph (d) of this section. (2) Collection and submission of performance measurement data in accordance with paragraph (c) of this section. (3) Mechanisms to detect both underutilization and overutilization of services. (4) Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under §438.340. (5) For MCOs, PIHPs, or PAHPs providing long-term services and supports: (i) Mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan, if applicable; and (ii) Participate in efforts by the State to prevent, detect, and remediate critical	**MED: 3/4** **Not Met:** 438.330 (b)(1)	MED7	health, but do not specifically address the CFR requirements. PHM1 and PHM6 require a strategy (with annual evaluation) to address member needs across the continuum, but do not specifically reference those with special health care needs.		plan and QAPI annual report. **Other:** PIPs are reviewed and validated by the EQRO annually. DHS also monitors under- and over-utilization of services regularly through analysis of encounter data. As part of the pay for performance (P4P) requirements, DHS evaluates quality of care at least on an annual basis through specific	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
incidents (consistent with assuring beneficiary health and welfare per §§441.302 and 441.730(a) of this chapter) that are based, at a minimum, on the requirements on the State for home and community-based waiver programs per §441.302(h) of this chapter.			The MED standards address monitoring for over- and under-utilization, as well as mechanisms to assess the quality and appropriateness of care provided to members with special health care needs. However, the standards do not address or require performance improvement projects.		performance indicators. See P4P requirements in the 2020 MCO P4P Guide. **1/1**	

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.330 (c) (c) *Performance measurement.* The State must— (1)(i) Identify standard performance measures, including those performance measures that may be specified by CMS under paragraph (a)(2) of this section, relating to the performance of MCOs, PIHPs, and PAHPs; and (ii) In addition to the measures specified in paragraph (c)(1)(i) of this section, in the case of an MCO, PIHP, or PAHP providing long-term services and supports, identify standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving long-term services and supports. (2) Require that each MCO, PIHP, and PAHP annually— (i) Measure and report to the State on its performance, using the standard measures required by the State in paragraph (c)(1) of this section; (ii) Submit to the State data, specified by the State, which enables the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State under paragraph (c)(1) of this section; or	**0/1** **Not Met:** 438.330 (c) Performance measurement 438.330 (c)(1)(ii) is N/A and was not included in the total elements.	None	**Not Met** No reference for reporting obligations to outside entities is found in the standards.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article X. Quality Assessment and Performance Improvement.	**1/1** **2021 Certification Application:** The Application requires the MCO to describe its system's ability to provide data necessary to monitor program performance relative to P4P. **Other:** The MCO *Quality Guide* lists the performance measures used in the P4P program. As part of the P4P requirements, DHS evaluates quality of care	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(iii) Perform a combination of the activities described in paragraphs (c)(2)(i) and (ii) of this section.					at least on an annual basis through specific performance indicators. See P4P requirements in the 2021 MCO *Quality Guide*. The P4P measures are validated by the EQRO annually.	
438.330 (d) (d) *Performance improvement projects.* (1) The State must require that MCOs, PIHPs, and PAHPs conduct performance improvement projects, including any performance improvement projects required by CMS in accordance with paragraph (a)(2) of this section, that focus on both clinical and nonclinical areas.	**1/5** **Not Met:** 438.330 (d)(2) (d)(2)(i) (d)(2) (iii) (d)(2) (iv)	QI1 QI3 QI4	**Not Met** While NCQA standards address the need to complete QI activities that address quality and safety of care	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article X Quality Assessment and Performance Improvement (QAPI), defines the process for MCOs to submit Performance Improvement Projects (PIPs) to DHS, the timeframe, and all the	**4/4** **2020 and 2021 Certification Applications:** The Certification process does not address	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(2) Each performance improvement project must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements: (i) Measurement of performance using objective quality indicators. (ii) Implementation of interventions to achieve improvement in the access to and quality of care. (iii) Evaluation of the effectiveness of the interventions based on the performance measures in paragraph (d)(2)(i) of this section. (iv) Planning and initiation of activities for increasing or sustaining improvement. (3) The State must require each MCO, PIHP, and PAHP to report the status and results of each project conducted per paragraph (d)(1) of this section to the State as requested, but not less than once per year. (4) The State may permit an MCO, PIHP, or PAHP exclusively serving dual eligibles to substitute an MA Organization quality improvement project conducted under §422.152(d) of this chapter for one or more of the performance improvement projects otherwise required under this section.			and quality of service, it is not specific in verifying that the plan has implemented specific performance improvement projects, meeting specific requirements, to impact care every year.	requirements they need to include in the PIP.	PIP requirements. **Other:** DHS, along with the EQRO, reviews PIP topics for all MCOs annually. DHS approves the topics, based on input from the EQRO. Final PIP reports are submitted annually by each MCO. The EQRO validates the final reports and provides written feedback to each MCO.	
438.330 (e) (e) *Program review by the State.*	**0/1**	None	**Not Met**	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:**	**0/1**	**1** (e)(1)

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(1) The State must review, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP, and PCCM entity described in §438.310(c)(2). The review must include— (i) The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report. (ii) The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (iii) The results of any efforts by the MCO, PIHP, or PAHP to support community integration for enrollees using long-term services and supports. (2) The State may require that an MCO, PIHP, PAHP, or PCCM entity described in §438.310(c)(2) develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program.	**Not Met:** 438.330 (e) 438.330(e)(1)(iii) is N/A.		No reference is found in the NCQA standards for external reporting obligations beyond making the QAPI program information available to members annually. NCQA does not address any regulatory oversight for the QAPI program.	Article X. Quality Assessment and Performance Improvement (QAPI) The QAPI is not monitored or reviewed annually, but must be made available to the Department upon request.	**2021 Certification Application:** The 2021 Certification Application does request the MCO's most recent Quality Assessment/Performance Improvement (QAPI) work plan and QAPI annual report. **Other:** The MCO *Quality Guide* lists the performance measures used in the pay-for-performance program. DHS, along with the EQRO, reviews PIP topics for all MCOs	The element is addressed in the 2020-2021 contract, but is not included in the current certification process.

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
					annually and DHS approves the topics, based on input from the EQRO. Once the final PIP reports are submitted, the EQRO validates the final report and provides feedback to each MCO. The EQRO validates the required performance measures annually.	

42 CFR 438 Managed Care - Subpart F

Grievance Systems

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.400 Statutory basis, definitions, and applicability. (a) Statutory basis. This subpart is based on the following statutory sections: (1) Section 1902(a)(3) of the Act requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly. (2) Section 1902(a)(4) of the Act requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan. (3) Section 1932(b)(4) of the Act requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. (4) Section 1859(f)(8)(B) of the Act requires that the Secretary, to the extent feasible, establish procedures unifying grievances and appeals procedures under sections 1852(f), 1852(g), 1902(a)(3), 1902(a)(5), and	**0/1**	ME7	**Not Met** The standards that address appeals and grievances do not include specific references to providers acting on behalf of an enrollee, except for expedited appeals and relative to an appeal involving an independent review entity. While a reference to access to an independent review entity	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article IX Member Grievances and Appeals requires MCO's to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide* ***Member Grievances and Appeals Guide*** Section 1 requires all Wisconsin Medicaid Health Plans to implement and enforce all of the requirements regarding member grievance and appeals processes, adhering to the requirements of the Guide.	**0/1** **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements.	**1** All elements are addressed in the 20-21contract, but none are included in the 2020 and 2021 Certification Application.

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
1932(b)(4) of the Act for items and services provided, by specialized Medicare Advantage plans for special needs individuals described in section 1859(b)(6)(B)(ii), under Titles XVIII and XIX of the Act. (b) Definitions. As used in this subpart, the following terms have the indicated meanings: Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following: (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (2) The reduction, suspension, or termination of a previously authorized service. (3) The denial, in whole or in part, of payment for a service. (4) The failure to provide services in a timely manner, as defined by the State. (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.			is noted, the standards do not reference the fair hearing process.			

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network. (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities. Appeal means a review by an MCO, PIHP, or PAHP of an adverse benefit determination. Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. Grievance and appeal system means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well						

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
as the processes to collect and track information about them. State fair hearing means the process set forth in subpart E of part 431 of this chapter. (c) Applicability. This subpart applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, states, MCOs, PIHPs, and PAHPs are required to continue to comply with subpart F contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.						
438.402 General requirements (a) The grievance and appeal system. Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in §438.9, are not subject to this subpart F. For grievances and appeals at the plan level, an applicable integrated plan as defined in §422.561 of this chapter is not subject to this subpart F, and is instead subject to the requirements of §§422.629 through 422.634 of this chapter. For appeals of integrated reconsiderations, applicable integrated plans are subject to §438.408(f). (b) Level of appeals. Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.	**3/8** **Not Met:** 438.402 (b), (c)(2)(i) and (ii) and (3)(i) and (ii) 438.402 (c)(i)(A) and (B) are NA and were not included in the total elements.	ME7 UM8	**Not Met** See notes above about the absence of references to providers acting on behalf of an enrollee. For grievances, no timeframes are specifically identified, but rather are	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article IX Member Grievances and Appeals requires MCO's to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide* ***Member Grievances and Appeals Guide*** Section 4 states each MCO must have a grievance and appeal system in place for its members. The	**0/5** **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements.	**5** All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certificati

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(c) Filing requirements—(1) Authority to file. (i) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld. (A) Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing. (B) External medical review. The State may offer and arrange for an external medical review if the following conditions are met. (1) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing. (2) The review must be independent of both the State and MCO, PIHP, or PAHP. (3) The review must be offered without any cost to the enrollee. (4) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420.	**MED: 3/8 Not Met:** 438.402 (b), (c)(2)(i) and (ii) and (3)(i) and (ii)	MED10	noted in a general manner. The MED standards provide general requirements for a grievance and appeal process, but do not meet the specific CFR requirements.	MCO's policies and procedures must detail what the grievance and appeal system is and how it operates. The section also states the levels of appeals permitted, filing requirements, member filing timeframes and the procedures for filing.	**0/5**	on Application. **5**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
* (ii) If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee. When the term "enrollee" is used throughout subpart F of this part, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request continuation of benefits as specified in §438.420(b)(5). (2) Timing—(i) Grievance. An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (ii) Appeal. Following receipt of a notification of an adverse benefit determination by an MCO, PIHP, or PAHP, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan. (3) Procedures—(i) Grievance. The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO, PIHP, or PAHP. (ii) Appeal. The enrollee may request an appeal either orally or in writing.						
438.404 Timely and adequate notice of adverse benefit determination	**0/3**	ME7	**Not Met**	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:**	**0/3**	**3**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(a) *Notice.* The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in §438.10. (b) *Content of notice.* The notice must explain the following: (1) The adverse benefit determination the MCO, PIHP, or PAHP has made or intends to make. (2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (3) The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal described at §438.402(b) and the right to request a State fair hearing consistent with §438.402(c). (4) The procedures for exercising the rights specified in this paragraph (b).	**Not Met:** 438.404 (a), (b) and (c) **0/3** **Not Met:** 438.404 (a), (b) and (c)	MED8 MED9 MED10 MED12	Notices are not required if the denial is either concurrent or post-service and the member is not at financial risk. While the standards include references to details such as the timeframe for appeal, how to submit information, and the timeframe within which the plan must make a decision, the standards do not include sufficient	Article IX Member Grievances and Appeals requires MCO's to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide* ***Member Grievances and Appeals Guide*** Section 5 outlines the MCO requirements for providing notice of adverse benefit determinations to member, including the content and timing of the notice. Appendix B: *Member Letter Templates and Mandatory Language for Member Letters* provides the standard language required for all member letters	**2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements. **0/3**	All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application.

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(5) The circumstances under which an appeal process can be expedited and how to request it. (6) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services. (c) *Timing of notice.* The MCO, PIHP, or PAHP must mail the notice within the following timeframes: (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter. (2) For denial of payment, at the time of any action affecting the claim. (3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1). (4) If the MCO, PIHP, or PAHP meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with §438.210(d)(1)(ii), it must— (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the			detail to fully meet federal requirements. The MED standards provide additional requirements for grievances and appeals, but do not contain sufficient detail to fully meet the federal requirements.			**3**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
right to file a grievance if he or she disagrees with that decision; and (ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. (6) For expedited service authorization decisions, within the timeframes specified in §438.210(d)(2).						

438.406 Handling of grievances and appeals (a) *General requirements.* In handling grievances and appeals, each MCO, PIHP, and PAHP must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (b) *Special requirements.* An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must: (1) Acknowledge receipt of each grievance and appeal. (2) Ensure that the individuals who make decisions on grievances and appeals are individuals— (i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. (ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease. (A) An appeal of a denial that is based on lack of medical necessity. (B) A grievance regarding denial of expedited resolution of an appeal. (C) A grievance or appeal that involves clinical issues.	**4/7** **Not Met:** 438.406(a), (b)(4) and (6)	ME7 UM8	**Not Met** The standards do not address the following elements: • Require provision of assistance to the enrollees to access grievance and appeal systems, except to provide interpretation assistance; • The option to allow deceased enrollee's legal representative to appeal; • In-person presentati	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article IX Member Grievances and Appeals requires MCO's to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide* ***Member Grievances and Appeals Guide*** Section 6 outlines the requirement for MCOs to provide reasonable assistance to members when filing a grievance or appeal. The section further outlines the requirements for handling member grievances and appeals for adverse benefit determinations.	**0/3** **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements.	**3** All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application.

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(iii) Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. (3) Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals. (4) Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO, PIHP, or PAHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution. (5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in	**MED: 4/7** **Not Met:** 438.406(a), (b)(4) and (6)	MED8 MED10	on of informati on. NCQA standards related to expertise of those hearing an appeal are limited to medical necessity appeals only. The option to examine case files and medical records is noted, but more in the past tense as part of the interaction following a utilization management decision.		**0/3**	**3**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
advance of the resolution timeframe for appeals as specified in §438.408(b) and (c). (6) Include, as parties to the appeal— (i) The enrollee and his or her representative; or (ii) The legal representative of a deceased enrollee's estate.			The MED standards provide additional requirements for grievances and appeals, but do not contain sufficient detail to fully meet the federal requirements.			
438.408 Resolution and notification: Grievances and appeals (a) *Basic rule.* Each MCO, PIHP, or PAHP must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section. (b) *Specific timeframes*—(1) *Standard resolution of grievances.* For standard resolution of a grievance and notice to the affected parties, the timeframe is established	**3/13** **Not Met:** 438.408 (a), b(1) and (2), (c)(2)(ii), d(1), e(1) and (2), and f(1), (2) and (3) 438.408(f)(1)(i) and (ii) are NA.	ME7 UM8 UM9	**Not Met** In general, policies for complaints and appeals are evaluated against the MCO's standards for timeliness, not specific timeframes associated	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article IX Member Grievances and Appeals requires MCO's to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide*	**0/10** **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements.	**10** All elements are addressed in the 2020-2021 contract, but not all are included

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (2) *Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section. (3) *Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section. (c) *Extension of timeframes.* (1) The MCO, PIHP, or PAHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if— (i) The enrollee requests the extension; or (ii) The MCO, PIHP, or PAHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.			with federal requirements. The timeframe for internal appeal resolution in the guidelines is 30 days from receipt of appeal for pre-service, 60 days for post-service and 72 hours for expedited appeals. NCQA guidelines state the organization records the time and date of the notification and identifies the staff	***Member Grievances and Appeals Guide*** Section 7 outlines the requirements for resolution and notification for all appeals and grievances including timeframes, extensions, format of notices, and content of notices to members.		in the 2020 or 2021 Certification Application.

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(2) *Requirements following extension.* If the MCO, PIHP, or PAHP extends the timeframes not at the request of the enrollee, it must complete all of the following: (i) Make reasonable efforts to give the enrollee prompt oral notice of the delay. (ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision. (iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (3) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing. (d) *Format of notice*—(1) *Grievances.* The State must establish the method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at §438.10.			member that spoke with the member or practitioner. The notification process evaluation does not address communication of the potential for financial responsibility for services received under a continuation of benefits.			

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(2) *Appeals.* (i) For all appeals, the MCO, PIHP, or PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at §438.10. (ii) For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice. (e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following: (1) The results of the resolution process and the date it was completed. (2) For appeals not resolved wholly in favor of the enrollees— (i) The right to request a State fair hearing, and how to do so. (ii) The right to request and receive benefits while the hearing is pending, and how to make the request. (iii) That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (f) *Requirements for State fair hearings*—(1) *Availability.* An enrollee may request a State fair hearing only after receiving notice that						

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
the MCO, PIHP, or PAHP is upholding the adverse benefit determination. (i) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing. (ii) *External medical review.* The State may offer and arrange for an external medical review if the following conditions are met. (A) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing. (B) The review must be independent of both the State and MCO, PIHP, or PAHP. (C) The review must be offered without any cost to the enrollee. (D) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420. (2)*State fair hearing.* The enrollee must have no less than 90 calendar days and no more than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution to request a State fair hearing.						

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(3) *Parties.* The parties to the State fair hearing include the MCO, PIHP, or PAHP, as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.						
438.410 Expedited resolution of appeals (a) *General rule.* Each MCO, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (b) *Punitive action.* The MCO, PIHP, or PAHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal. (c) *Action following denial of a request for expedited resolution.* If the MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it must— (1) Transfer the appeal to the timeframe for standard resolution in accordance with §438.408(b)(2).	**1/3** **Not Met:** 438.410 **(**b) and (c) **MED: 2/3** **Not Met:** 438.410 **(**b)	ME7 MED10	**Not Met** NCQA standards do not include references to assurances that providers do not suffer punitive action through their involvement in appeals and does address transfer to the standard process for appeals.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article IX Member Grievances and Appeals requires MCO's to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide* ***Member Grievances and Appeals Guide*** Section 8 requires MCOs to establish a process for expedited appeals, including prohibiting punitive action and steps that must be taken when the request for an expedited appeal is denied.	**0/2** **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements. **0/1**	**2** All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application.

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(2) Follow the requirements in §438.408(c)(2).			The MED standards provide additional requirements for grievances and appeals, but do not contain sufficient detail to fully meet the federal requirements.			**1**
438.414 Information about the grievance and appeal system to providers and subcontractors The MCO, PIHP or PAHP must provide information specified in §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.	**0/1** **Not Met:** 438.414 **MED: 1/1**	None MED10	**Not Met** NCQA standards do not address this requirement.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article IX Member Grievances and Appeals requires MCO's to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide* ***Member Grievances and Appeals Guide*** Section 13 requires MCOs to distribute the	**0/1** **2020 & 2021 Certification Applications:** The Certification Applications do not monitor or review these requirements.	**1** All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
			The MED standards require MCOs to distribute information about the grievance and appeal system to all providers at the time of contracting.	member grievance and appeals informational flyer to its gatekeepers, providers, subcontractors and Independent Practice Associations along with the *Member Grievances and Appeals Guide* at the time of contracting and within three weeks of updates thereafter. The MCOs must also ensure these entities have written procedures addressing how members are informed of a denied service.	**0/1**	2021 Certification Application. **1**
438.416 Recordkeeping requirements (a) The State must require MCOs, PIHPs, and PAHPs 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. (b) The record of each grievance or appeal must contain, at a minimum, all of the following information: (1) A general description of the reason for the appeal or grievance. (2) The date received.	**2/3** **Not Met:** 438.416(c) **MED: 2/3**	UM9 UM9 MED10	**Not Met** This standard includes requirements for documentation of complaints and appeals but without regard for the need for state oversight.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article IX Member Grievances and Appeals requires MCO's to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide*	**1/1** **2020 & 2021 Certification Applications:** The Certification Applications do not monitor or review these requirements.	**None**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
(3) The date of each review or, if applicable, review meeting. (4) Resolution at each level of the appeal or grievance, if applicable. (5) Date of resolution at each level, if applicable. (6) Name of the covered person for whom the appeal or grievance was filed. * (c) The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.	**Not Met:** 438.416(c)		The MED standards provide additional requirements for grievances and appeals, but do not contain sufficient detail to fully meet the federal requirements.	***Member Grievances and Appeals Guide*** Section 11 specifies the MCO recordkeeping requirements and grievance report quarterly submissions to DHS. Section 12 specifies the information and formatting of the quarterly submissions. The reports address all requirements except (b)(3)	**Other:** The *Member Grievances and Appeals Guide* requires all MCOs to submit quarterly reports to DHS of all grievances and appeals. DHS conducts random reviews to ensure the requirements are met.	
438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending (a) *Definition.* As used in this section—	**2/4** **Not Met:** 438.420 (a) and (c)	UM8	**Not Met** While the general concepts of these federal	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article IX Member Grievances and Appeals requires MCO's to	**0/2** **2020 & 2021 Certification Application:**	**2** All elements are

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
Timely files means files for continuation of benefits on or before the later of the following: (i) Within 10 calendar days of the MCO, PIHP, or PAHP sending the notice of adverse benefit determination. (ii) The intended effective date of the MCO's, PIHP's, or PAHP's proposed adverse benefit determination. (b) *Continuation of benefits.* The MCO, PIHP, or PAHP must continue the enrollee's benefits if all of the following occur: (1) The enrollee files the request for an appeal timely in accordance with §438.402(c)(1)(ii) and (c)(2)(ii); (2) The appeal involves the termination, suspension, or reduction of previously authorized services; (3) The services were ordered by an authorized provider; (4) The period covered by the original authorization has not expired; and (5) The enrollee timely files for continuation of benefits. (c) *Duration of continued or reinstated benefits.* If, at the enrollee's request, the MCO, PIHP, or PAHP continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits	**MED: 2/4**	MED11	requirements are addressed in NCQA standards, specific details, especially those related to criteria for continuation of benefits are not included.	implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide* ***Member Grievances and Appeals Guide*** Section 9 outlines the requirements for continuation of benefits during the appeal and State Fair Hearing process, including timely filing, continuation of benefits, duration of benefits and the member's financial responsibility.	The Certification Applications do not monitor or review these requirements. **Other:** The *Member Grievances and Appeals Guide* requires all MCOs to submit quarterly reports to DHS of all grievances and appeals. DHS conducts random reviews to ensure most requirements are met, but does not	addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application. The quarterly grievance and appeals report required in the *Member Grievances and Appeals Guide* does not include all

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
must be continued until one of following occurs: (1) The enrollee withdraws the appeal or request for state fair hearing. (2) The enrollee fails to request a state fair hearing and continuation of benefits within 10 calendar days after the MCO, PIHP, or PAHP sends the notice of an adverse resolution to the enrollee's appeal under §438.408(d)(2). (3) A State fair hearing office issues a hearing decision adverse to the enrollee. (d) *Enrollee responsibility for services furnished while the appeal or state fair hearing is pending.* If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the MCO's, PIHP's, or PAHP's adverse benefit determination, the MCO, PIHP, or PAHP may, consistent with the state's usual policy on recoveries under §431.230(b) of this chapter and as specified in the MCO's, PIHP's, or PAHP's contract, recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.	**Not Met:** 438.420 (a) and (c)		The MED standards provide additional requirements for grievances and appeals, but do not contain sufficient detail to fully meet the federal requirements.		fully address the continuation of benefits. **0/2**	requirements for the continuation of benefits. **2**

Federal Requirement	Elements Met with NCQA Accreditation/ Total Elements	NCQA Standard Reference	Summarized NCQA Accreditation Standard	DHS Contract Requirements	Remaining Elements Met with DHS Certification	Gap Elements Remaining
438.424 Effectuation of reversed appeal resolutions *(a) Services not furnished while the appeal is pending.* If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (b) *Services furnished while the appeal is pending.* If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO, PIHP, or PAHP, or the State must pay for those services, in accordance with State policy and regulations.	**0/2** **Not Met:** 438.424 (a) and (b) **MED: 2/2**	None MED10	**Not Met** NCQA standards do not reflect the details included this requirement. The MED standards address the effectuation of reversed appeal decisions.	**2020-2021 BadgerCare Plus and Medicaid SSI Contract:** Article IX Member Grievances and Appeals requires MCO's to implement and enforce all requirements regarding member grievance and appeals processes as contained in the *Member Grievances and Appeals Guide* ***Member Grievances and Appeals Guide*** Section 10 requires MCOs to authorize or provide disputed services no later than 72 hours from the date it receives notice reversing the determination. The MCO must also pay for any disputed services the member received while the appeal was pending.	**0/2** **2020 & 2021 Certification Application:** The Certification Applications do not monitor or review these requirements. **None**	**2** All elements are addressed in the 2020-2021 contract, but not all are included in the 2020 or 2021 Certification Application. **None**

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/contract.htm

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

Care4Kids Quality Guide:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/pdf/Care4Kids_QG_2020.pdf.spage

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

Care4Kids Contract:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Managed_Care_Medical_Homes/Home.htm.spage

Children Come First and Wraparound Milwaukee Contracts:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Contracts/Home.htm.spage

HIV/AIDS Health Home and Obstetrics Medical Home:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Managed_Care_Medical_Homes/Home.htm.spage