2021 Wisconsin Medicaid Managed Care Quality Strategy: Effectiveness Evaluation

This is the first Effectiveness Evaluation submission for the Wisconsin Division of Medicaid Services (DMS) Medicaid Managed Care Quality Strategy (Quality Strategy). Since the 2018 submission of the Quality Strategy (linked in Appendix A), a number of improvements are being made. Identification of improvement opportunities emerged from 1) the 2018 quality strategy public comments, 2) feedback from the Centers for Medicare & Medicaid Services (CMS) Managed Care Team on the 2018 quality strategy, and 3) internal review and reflection within the DMS interdisciplinary quality team, including feedback from our External Quality Review Organization (EQRO), MetaStar.

Key improvements to the Quality Strategy are described in the Effectiveness Evaluation and are summarized as follows:

1. Alignment of Quality Goals to Measureable Objectives
2. Selection of Performance Metrics Based on Measurement Best Practices
3. Inclusion of Baseline Data and Target-Setting for Performance Metrics
4. Development of an Ongoing Effectiveness Evaluation System for Continuous Improvement
5. Increased Focus on Reducing Health Disparities

Improvement 1: Alignment of Quality Goals to Measureable Objectives

Although aligned with the values and foundational principles of the DMS, the Quality Strategy goals and objectives required more specificity. The 2021 Quality Strategy reflects the measurement of goals tied to specific objectives using existing performance measures. This data-driven approach will allow DMS to assess whether its goals and objectives are being achieved relevant to program outcomes.

The acute and primary and long-term managed care programs share the mission of providing person-centered care and enabling cost-effective and equitable access to care. However, in order to improve the specificity of the objectives and desired outcomes for program members in each of these areas, separate goals and objectives are now identified for each program area. For example, community inclusion and a person's sense of choice and control over their services are outcomes particularly relevant to the Family Care and Family Care Partnership populations, whereas clinical outcomes such as prenatal and postpartum care are especially relevant to the BadgerCare Plus and SSI populations. Splitting the acute and primary and long-term managed care goals and objectives also improves the clarity of which performance measures are available for beneficiaries in each program.

Improvement 2: Selection of Performance Metrics Based on Measurement Best Practices

The Wisconsin DMS monitors an array of input, process, and outcome measures. The key task of the Quality Strategy is to prioritize a manageable set of metrics that are focused on member outcomes, accurately measured, reliably reported, and actionable for quality improvement. An additional factor in the selection of the Quality Strategy metrics is to select measures 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 other state health systems. Considering these factors, the quality team evaluated and determined which performance indicators to include in the 2021 Quality Strategy goals and objectives. 12 performance metrics were identified for acute and primary managed care, and 17 performance metrics were identified for long term managed care. Additionally, all performance metrics for the Care4Kids medical home program are included in the strategy for the first time.

The 12 Acute and Primary Care performance metrics selected for monitoring within the Quality Strategy are those measures where improvement targets are established as part of the 2020 Pay-for-Performance (P4P) program. Each year, HMOs submit performance metric results for all HEDIS measures in the CMS Adult Core Set and Child Core Set to DMS. While all Adult and Child Core Set HEDIS measures are required reporting to DMS for all HMOs, with the risk of a financial penalty for not reporting, a subset of these Core Set measures are designated as Pay-for-Performance measures. For each Pay-for-Performance measure, HMOs can earn back part of the withheld capitated amount associated with that measure relative to the level at which the quality target is met. Quality targets are set annually based on the NCQA Quality Compass national percentile rates for each measure, along with the statewide rate in some cases. The 12 Pay-for-Performance measures reflect DMS prioritization of selected HEDIS measures for which HMOs are rewarded for high member outcomes or significant quality improvements. The Quality Strategy contextualizes these performance measures by four of the CMS Core Set Domains: 1) Primary Care Access and Preventive Care, 2) Maternal and Perinatal Health, 3) Care of Acute and Chronic Conditions, and 4) Behavioral Health Care. DMS has an annual process to evaluate which measures should be included in the HMO P4P or WI Core Reporting initiatives, including determining which measures to collect or incentivize, the target for each measure, how much incentive amount should be assigned for each measures, and when to add or retire measures from incentives or from reporting. This annual process to select and incentivize measures results in the HMO Quality Guide issued each measurement year.

The 17 Long-Term Care performance metrics were selected using recommendations from the Home and Community-Based Services (HCBS) Recommended Measures Set. In fall of 2020, CMS issued a Request for Information on its development of a draft set of recommendations for a comprehensive set of performance measures assessing the quality of HCBS. The alignment between the CMS-recommended measures and the HCBS domains of quality established by the National Quality Forum (NQF) provided Wisconsin DMS with a best practice framework for

organizing and prioritizing key measures of interest. Using the NQF Domains of HCBS Quality, Wisconsin DMS translated each of the 11 domains into goals for long-term managed care. For each of the domains, DMS selected one to two Base Set or Extended set performance metrics as recommended by CMS. Many of these performance metrics come from Wisconsin's results on the National Core Indicators In-Person Survey (NCI-IPS) and Aging and Disability (NCI-AD) surveys. Long-Term Care beneficiaries' self-reported satisfaction with their services received, sense of well-being, choice, community inclusion, and other factors provide a strong sense of how well beneficiaries achieve outcomes related to quality of life.

Improvement 3: Inclusion of Baseline Data and Target-Setting for Performance Metrics

The 2021 Medicaid Managed Care Quality Strategy sets a new Wisconsin standard of articulating specific goals and objectives associated with performance measures. DMS looks to increase positive outcomes across performance measures by monitoring annual results and looking for trends in the positive direction; measures that indicate a deficiency or lack of progress benefit from setting performance improvement targets. The purpose of setting targets for performance measures is to set an expectation for improvement on the selected measures, then working to achieve these targets. DMS exercises discretion in setting targets to direct areas of focus; as such, not every performance measure DMS monitors has a numerical target. As a proxy for a numerical target set for each measure, the Goals and Objectives indicate either a national percentile or a national average rate for applicable measures. These national percentiles and averages are used as a comparison to indicate how well Wisconsin performs on the measure relative to national data.

Acute and Primary Care

The "targets" set for the current annual Acute and Primary Care performance measures are expressed using the national Bottom (25th), Median (50th), and Top (75th) Percentile results for that measure using recent actual performance data. These quartile data come from the NCQA Quality Compass and are used to assess which percentile the state average result falls into for that measure. If no national data is available, then DMS looks to the state average to determine improvement targets. As an example, for 2021 HEDIS measures, the target for an individual measure may be based on the 75th percentile of Measurement Year 2019 national performance for that measure, if that is the next highest incremental goal for the HMO. For HMO Pay-for-Performance measures, financial incentive is awarded to the HMO proportionate based on a point system to recognize achieving a high degree of performance and/or a high degree of improvement.

Long-Term Care

The majority of performance measures selected for Long-Term Care are National Core Indicators (NCI) survey questions. The "targets" expressed for these performance measures are the average national rate for that measure. Caution should be exercised when interpreting these national rates, as state differences, when close to the national NCI average, may not be significantly different than the national NCI average. Therefore, the national results provides a sense for national performance on the data, which can be compared to the state performance. In

the published national reports, NCI averages are "weighted" to reflect the state's relative population and sample sizes, meaning that data submitted by each state is proportional to its service population. In addition, state averages are listed as above, within, and below average to the national average. The results should not be used to compare one state to another but rather show trends over time. NCI measures include more than just managed care, so different states may have different program types and acuity of people enrolled. Wisconsin also oversamples by program and target group for both the NCI Aging and Disability (AD) survey for older adults and people with physical disabilities and the NCI In Person Survey (IPS) for people with developmental disabilities. The NCI AD survey breaks out these groups whereas NCI IPS displays aggregate results for all groups.

Improvement 4: Development of an Ongoing Effectiveness Evaluation System for Continuous Improvement

In 2020, an organizational structure change occurred within the DMS, bringing both the acute and primary managed care and the long term managed care programs together under the same quality management system. This merger allows for more collaboration across these programs to strengthen the alignment and synchrony between programs, respective quality strategy goals, and overall quality oversight.

While evaluating the 2018 Medicaid Managed Care Quality Strategy and the past three years of the Wisconsin Division of Medicaid Services' quality improvement system in the context of the structural change, DMS identified the need to infuse ongoing, data-driven process and outcomes review into its organizational culture of quality and equity as an area for improvement. Both comprehensiveness and innovativeness are underlying requirements of the Quality Strategy, where a consideration for what we know is balanced with a consideration for where we want to grow. Though both of these aspects of quality improvement coincide, each requires its own process improvement lens.

Comprehensiveness: The quality strategy uses process and outcome measures to assess how well programs currently achieve member outcomes and identify the most impactful opportunities for improvement.

The first requirement of the Quality Strategy is to have a comprehensive grasp of what DMS already knows about the quality of managed care programs. For example, on an annual basis DMS monitors HMO performance on the CMS Adult and Child Core Set HEDIS measures. DMS also monitors results of the National Core Indicators surveys (NCI-IPS and NCI-AD) for MCO members. DMS analyzes data and feedback from the EQRO on key program compliance areas through the MCO Care Management Review and Quality and Compliance Review. Each of these tools serve as input for quality measurement and provide us with a foundation for what we know.

To begin our quality review process, we ask, "Based on the data we have available, how well are programs doing on improving member outcomes?" To respond to this question and organize and communicate the collection of input, process, and outcome measures, DMS annually updates dashboards, scorecards, and reports, which aggregate key performance indicators from these data

sources. The Adult Long-Term Care Scorecard and HMO Quality guide are examples of essential aggregated reports. Historical data on the measures displayed in these reports help to indicate whether outcomes are trending in a positive or negative direction.

While such analyses are regularly conducted by the quality team, the team has identified the essential quality objective of promoting and expanding awareness of current quality outcomes with the larger group of program staff and leadership. While the formal three-year effectiveness evaluation can present a retrospective analysis of the quality improvement system from the perspective of the quality team, an ongoing quality effectiveness evaluation process with emphasis on communication and shared data-driven decision-making with leadership will operationalize a more fluid, dynamic, and central quality improvement system.

Figure 1 illustrates a proposed communication and process improvement cycle for an Ongoing Quality Effectiveness Evaluation. The quality team annually receives new data, generates reports, conducts analyses, and presents results corresponding to the pieces of the circle below. This process of analyzing different sets of data occurs at different points within the calendar year, with internal and external stakeholders briefed on selected pieces throughout the year. The new Ongoing Quality Effectiveness Evaluation structure will provide regular "check points" throughout the year during which the quality team will engage with leadership on each of the quality measurement areas to facilitate comprehensive and incremental process improvement. This approach necessitates that a Quality Steering Committee is in place to engage all levels of leadership and subject matter experts in decision-making. This ongoing evaluation process will provide a timely and responsive system for cyclical quality improvement.

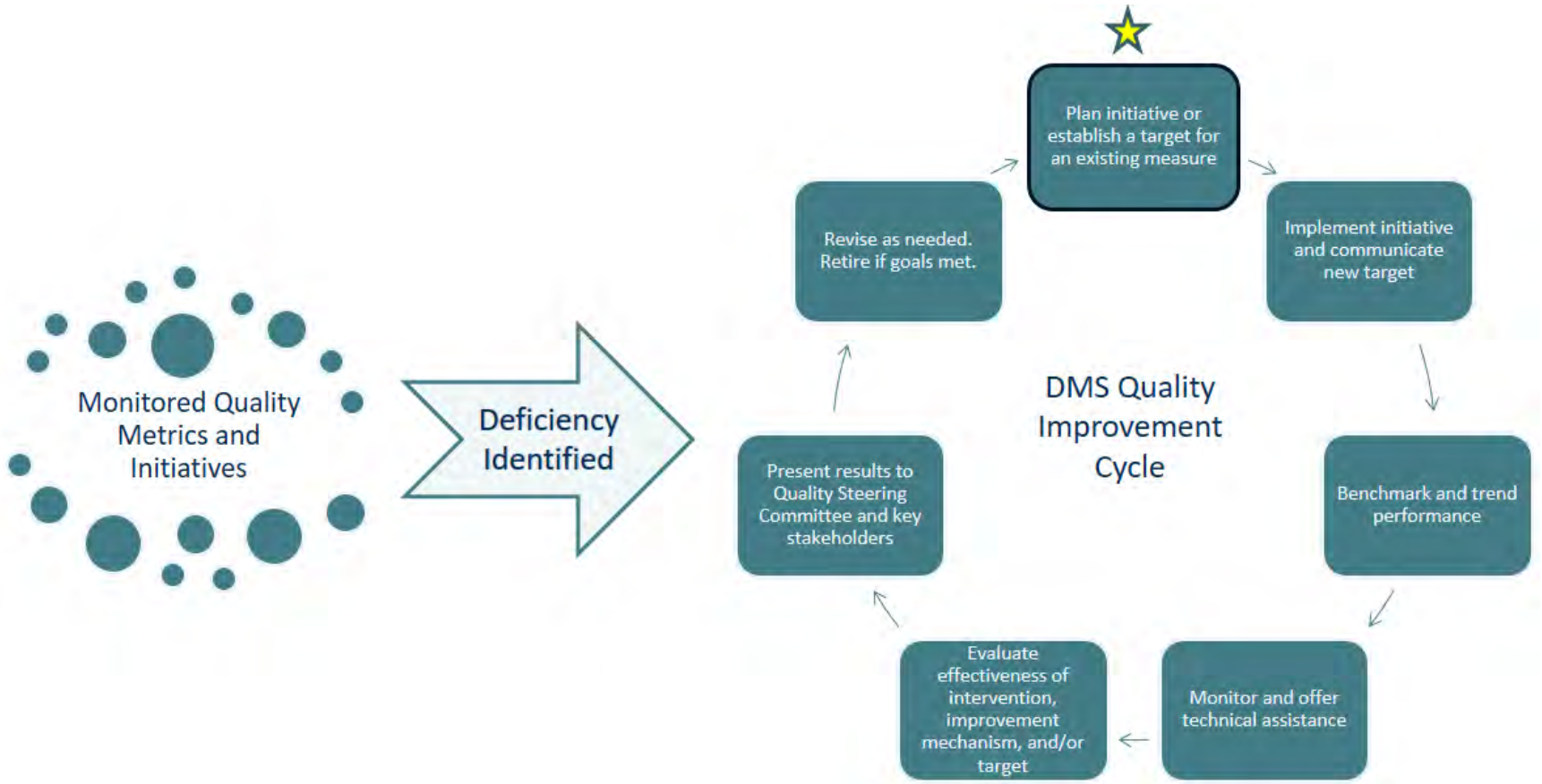
Monitored Quality Metrics and Initiatives
Deficiency Identified
DMS Quality Improvement Cycle
Plan initiative or establish a target for an existing measure
Implement initiative and communicate new target
Benchmark and trend performance
Monitor and offer technical assistance
Evaluate effectiveness of intervention, improvement mechanism, and/or target
Present results to Quality Steering Committee and key stakeholders
Revise as needed. Retire if goals met.

Figure 1

The question asked at each checkpoint of the Ongoing Quality Effectiveness Evaluation is, "Which outcomes indicate the most significant opportunities for improvement?" This analysis would consist of reviewing the satisfaction survey results dashboard or HEDIS measures trending table and pulling out the three lowest performing survey items or HEDIS measures. A discussion would then ensue on whether a formal improvement initiative or a financial or policy lever should be used to focus improvement on the identified items.

Innovativeness: The quality strategy identifies gaps in our quality management system, reflecting opportunities to assess outcomes on prioritized domains of quality and take action.

The second requirement of the Quality Strategy is to identify, prioritize, and address gaps in our quality improvement system. The key questions are: 1) Which areas are gaps in our quality management system, reflecting opportunities to capture new outcomes data on prioritized domains of quality? 2) What should we be tracking that we are not? 3) How do we develop relevant measures to new populations? 4) Where do we need to take action? In light of DMS's increased commitment to addressing health equity and drivers of health (DOH), reducing health disparities has become a primary focus of the overall 2021 quality strategy. In 2020, behavioral health and dental care were also identified as key areas that will benefit from more performance measurement research during the next Quality Strategy period.

Creating an organizational structure for comprehensive and innovative quality effectiveness evaluation

Foundational to addressing these comprehensive and innovative aspects of quality improvement, DMS has recognized the need to put in motion an organizationally engaged quality improvement system that is more dynamic than static. In order to yield impactful quality improvement actions from the quality evaluation system, a more formalized organizational hierarchy for quality awareness, communication, and evaluation is needed. Greater internal awareness of current quality outcomes will spark data-driven decision-making with program and division leaders engaged in analysis of quality outcomes for program members. Communication across program areas will increase exchange of best practices and reduce program compartmentalization. By fostering organizational investment in member outcomes through a data-informed lens, the organization will be better prepared to present external stakeholders with quality outcomes data and engage community leaders and program beneficiaries in co-development of quality improvement goals. DMS has increased our collaboration with stakeholders since the initial 2018 Quality Strategy submission. We began monthly HMO Quality Forums to discuss quality improvement initiatives more regularly, and developed several learning collaborative opportunities to have health plans or other external presenters share information with the group. Internally, there has been improved sharing across programs and/or work units to better share information with each other and find opportunities for alignment or efficiencies. The DMS works collaboratively with the Division of Public Health on quality improvement efforts, including sharing information and guidance with managed care organizations even prior to the public health emergency that started in 2020.

Improvement 5: Increased Focus on Reducing Health Disparities

In 2020, the Wisconsin DMS increased its attention to reducing health disparities by implementing Performance Improvement Projects (PIP) for its BadgerCare Plus HMOs. SSI HMOs are responsible for implementing PIPs this year (2021). Both BadgerCare Plus and SSI HMOs are required to complete two PIPs per year. For one of these PIPs, BadgerCare Plus HMOs are mandated to complete a project that reduces disparities in its postpartum care (PPC-AD) outcomes. This PIP emphasizes the reduction of health disparities in a clinical area where there are known disparate results based on data. This PIP also requires cultural self-assessments at the HMO and provider levels, which are then used as the basis for developing targeted health disparities reduction plans. For our 2020 and 2021 BadgerCare Plus HMO PIPs, we have incorporated culturally and linguistically relevant services in our approach to improving our PPC rates by requiring HMOs to provide access to community-based maternity care options and non-traditionally culturally competent maternity provider services (e.g. community health workers (CHW), traditional healers, doula services, peer supports, etc.). Medicaid MCOs also engaged in annual PIP projects where they are encouraged to analyze health disparities.

Acknowledging Wisconsin's disparate racial birth outcomes, the WI DMS's Obstetrics Medical Home (OBMH) program works to improve birth outcomes for all pregnant women within BadgerCare Plus, with particular interest on closing the disparities gap among its Black/African American member population. By focusing our efforts within the OBMH program on women who are at high risk for a poor birth outcome, we are able to require and provide continuity of care of provider for each woman in the program, and offer care that is continuous, coordinated, and comprehensive. Through our program, we also coordinate with Prenatal Care Coordination (PNCC), a Medicaid and BadgerCare Plus benefit that helps pregnant women get the support and services they need to have a healthy baby.

In 2020, the DMS began aligning all of its programs, quality strategies and initiatives with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards) and the National Quality Forum's (NQF) Roadmap to Health Equity. Combined, the CLAS Standards and NQF Roadmap provide a blueprint for identifying health disparities, strategies to implementing evidence-based interventions, health equity performance measure domains to invest in, and recommendations for incentivizing results of health disparities. We are actively evaluating all of our performance metrics and measures with an equity lens and to ensure CLAS Standards are incorporated or that collected data can be analyzed to identify health disparities. In 2021 we will be requiring HMOs to conduct a self-assessment of the drivers of health for which they screen their members so that we can better identify health disparities and inform our strategic approaches to addressing them. We believe this will result in significant improvements in our programs. An additional improvement of our strategy is that in 2021, we will begin receiving demographic data for some of our HMO HEDIS measures that will allow us to better measure and identify disparities along demographic populations. Using our HEDIS measures to measure disparities will inform our quality strategy approach moving forward. We view the collection of these health disparities reducing activities as advancements since our 2018 submission of Wisconsin's Medicaid Managed Care Quality Strategy.

Appendix A. Resources Referenced in Effectiveness Evaluation

1. 2018-2021 WI Medicaid Managed Care Quality Strategy: https://www.dhs.wisconsin.gov/publications/p02156.pdf

2. Annual External Quality Review Technical Reports completed during the 2018-2021 quality strategy period:
   A. Acute Care Managed Care Reports (BadgerCare Plus and Medicaid SSI HMOs, Care4Kids, Children Come First, and Wraparound Milwaukee programs)
      - CY 2019
      - CY 2018
   B. Long-Term Care Managed Care
      - 2018-2019