## Contents

Executive Summary ......................................................................................................................... 4  

1. Introduction .............................................................................................................................. 9  
   a. Purpose ............................................................................................................................... 9  
   b. Scope................................................................................................................................... 9  
   c. History of Medicaid in Wisconsin ..................................................................................... 10  

   a. Public Comment Process: §§ 438.202(b) and 438.340(c) and (d) .................................... 13  

3. Organizational Goals, Objectives, and Foundational Principles ............................................. 13  
   a. DHS Mission, Vision, and Values ....................................................................................... 14  
   b. DMS Mission, Vision, Values ............................................................................................. 14  
   c. Foundational Principles .................................................................................................... 14  
   d. DMS Quality Goals and Objectives: § 438.340(b)(2) ........................................................ 15  

4. DMS Quality Strategies: § 438.340(b) ..................................................................................... 19  
   a. Payment Strategies ........................................................................................................... 19  
      i. Enhance Pay-for-Performance .................................................................................... 20  
      ii. Implement Alternative Payment Models through BadgerCare Plus and SSI HMOs .. 20  
      iii. Reduce Avoidable, Non-Value Added Care .............................................................. 20  
   b. Delivery System and Person-Centered Care Strategies .................................................... 21  
      i. Enhance Care Coordination and Person-Centered Care ............................................ 21  
      ii. Improve Health Homes ............................................................................................... 22  
      iii. Ensure Health and Safety ............................................................................................ 22  
   c. Member Engagement and Choice Strategies ................................................................... 23  
      i. Promote Member Engagement .................................................................................. 23  
      ii. Long-Term Care Choice Strategy .............................................................................. 24  

5. Enabling Infrastructure: Data and Technology ....................................................................... 25  
   a. Accelerate Quality Monitoring ......................................................................................... 25  
   b. Use Technology to Engage Members ............................................................................... 26  

6. DMS Managed Care Programs ................................................................................................ 26  
   a. Acute Care Programs ........................................................................................................ 26
i. BadgerCare Plus HMOs ................................................................. 26
ii. SSI HMOs ......................................................................................... 28
iii. Care4Kids Health Home ............................................................... 29
iv. Children Come First / Wraparound Milwaukee ......................... 30
v. HIV/AIDS Health Home ................................................................. 30
vi. Obstetrics Medical Home ............................................................. 31
b. Long-Term Care Programs ........................................................... 32
   i. Family Care .................................................................................. 32
   ii. Family Care Partnership .............................................................. 33
6. Quality Assurance ........................................................................... 34
   a. Access Standards ........................................................................ 34
      i. Network Adequacy: § 438.340(b)(1) ........................................ 35
   b. Service Standards: §§ 438.340(b)(1) and 438.340(b)(5) .............. 36
      i. Evidence-Based Clinical Practice Guidelines ............................ 36
      ii. Members With Special Needs .................................................... 36
      iii. Transitions of Care Policy .......................................................... 36
      iv. Health Disparities .................................................................... 37
       i. Performance Improvement Projects ........................................ 39
    d. External quality review organization: §§ 438.340(b)(4) and 438.340(b)(10) 40
       i. Accreditation Deeming Plan: § 438.360 ................................... 41
    e. Remediation Plans ..................................................................... 42
       i. Intermediate Sanctions ............................................................. 42
7. Roadmaps ....................................................................................... 42
   a. Acute Care .................................................................................. 43
   b. Long-Term Care ......................................................................... 44
8. Appendices .................................................................................... 45
   a. Quality Framework .................................................................... 45
   b. Glossary of Terms ..................................................................... 48
   c. Quality Measure Matrix ............................................................. 57
i. Acute Care................................................................................................................... 57
ii. Long-Term Care.......................................................................................................... 58
d. Summary of Current Enabling Data and Technology Assets....................................... 60
e. Quality Strategy Public Comments ............................................................................. 63
f. Accreditation Plan......................................................................................................... 64
g. Supporting Documents for CMS Compliance Matrix Detail ....................................... 65
Executive Summary

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

The Quality Strategy was prepared by DMS in accordance with requirements from Centers for Medicare & Medicaid Services (CMS) for states to develop a strategy to assess and improve the quality of managed care services offered to Medicaid beneficiaries. It articulates compliance with the federal Medicaid managed care rule, 42 C.F.R. § 438.204 (2016) requirements. While the Quality Strategy is specifically focused on Wisconsin Medicaid members receiving acute and/or long-term managed care services, the quality goals apply to all programs in which Medicaid members are enrolled, including fee-for-service members.

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

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

Goals and objectives within these domains are presented below.

<table>
<thead>
<tr>
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<td>Control health care costs in BadgerCare Plus and SSI HMOs through enhanced value-based purchasing and efficiency.</td>
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<td>Increase the percentage of Family Care and Family Care Partnership members who report living in the setting they prefer.</td>
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## Health Outcomes and Reducing Disparities

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<td>Improve health outcomes for BadgerCare Plus and SSI HMO members at the individual and population health levels.</td>
<td>Ensure continuous improvement of high-quality programs to achieve the goals and outcomes identified by Family Care and Family Care Partnership members.</td>
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<td>• Increase the percentage of service plans that address the assessed needs and personal goals of Family Care and Family Care Partnership members.</td>
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<td>• Improve care and treatment for BadgerCare Plus and SSI members with mental health and substance abuse conditions.</td>
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To achieve these quality goals and objectives, DMS will employ three types of strategies: payment levers; delivery system and person-centered care approaches; and member engagement and choice initiatives.

**Payment:** DMS is expanding value-based reimbursement arrangements to increasingly align payments to health outcomes. These arrangements include pay-for-performance on clinical measures and member satisfaction scores, alternative payment models for BadgerCare Plus and SSI HMOs, and reducing potentially preventable hospital readmissions.
Delivery system and person-centered care: Delivery system strategies focus on the way HMOs, MCOs, and providers care for patients. These strategies emphasize care management and coordination, use of health homes and medical homes for specific conditions and populations, and continual attention to the health and safety of Medicaid members. Person-centered care strategies focus on building partnerships between members and their care teams around high-quality, evidence-based, accessible care in which individual needs, preferences, and values of members and caretakers are paramount.

Member engagement and choice: Member engagement and choice are critical strategies for promoting active participation of members in their own health care decisions, encouraging appropriate utilization of benefits, and ensuring that members receive services and supports according to their needs and preferences. These strategies involve providing culturally competent member services, objective information about care options, and support for employment. The Quality Strategy also describes the use of health information technology to support Medicaid business operations and administration, accelerate quality measurement and reporting, and facilitate member engagement. The document concludes with a section on quality assurance, which describes how DMS complies with the federal guidelines for ensuring the quality of care provided to members.
1. **Introduction**

Wisconsin Medicaid programs offer high-quality, person-centered managed care to members. The Wisconsin Medicaid Managed Care Quality Strategy document (Quality Strategy) outlines the Wisconsin Department of Health Services (DHS) Division of Medicaid Services (DMS) managed care quality goals, objectives, strategies, and programs intended to achieve the overarching goals of DMS, as well as to establish a process for monitoring progress toward these goals. In alignment with the Triple Aim, 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. § 438.204 (2013) to describe the strategies for assessment and quality improvement of managed care services offered to Medicaid beneficiaries. It includes the specific strategies Wisconsin will use to align programs to best meet the health care needs of Medicaid members and continually improve health for Wisconsin residents.

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

b. **Scope**

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

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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.

**GRAPHIC 1**

This document concludes with a section on quality assurance, which describes how DMS
complies with the federal guidelines, § 438.204, for ensuring the quality of care provided to
members.

c. **History of Medicaid in Wisconsin**

**Acute care:** In 1984, in several southeastern and southcentral counties, Wisconsin Medicaid
began paying for and delivering services through acute care HMOs. In 1994, Medicaid began
voluntary enrollment of populations with special health care needs in managed care programs,
including individuals deemed disabled and eligible for SSI. Wisconsin expanded the use of
HMOs to include most of the remainder of the state for the core Medicaid population in 1997
and SSI population in 2004. Beginning in the mid-1990s, Wisconsin developed a number of
voluntary managed care demonstration programs. Children Come First started in Dane County
in 1993 and Wraparound Milwaukee started in Milwaukee County 1997. These programs
provide behavioral health services to children with severe emotional disturbances in home and
community settings rather than in residential treatment centers and inpatient psychiatric
hospitals.
In 1999, Wisconsin added BadgerCare to provide Medicaid acute, primary, and behavioral services to parents and children. Then in 2008, under a federal demonstration waiver, BadgerCare merged Medicaid with Children’s Health Insurance Program to create BadgerCare Plus. From 2009 through 2013, eligibility was extended to childless adults with income up to 200% of the federal poverty level with a capped enrollment. In 2014, eligibility was amended to include parents and caregivers and childless adults with income up to 100% of the federal poverty level, covering all adults living in poverty for the first time. Wisconsin also received federal approval in 2014 to operate a medical home, Care4Kids, to provide benefits to foster children through a non-risk prepaid inpatient health plan. Currently, most BadgerCare Plus beneficiaries and SSI adults are required to enroll in a managed care plan.

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

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

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

In 2006, the Wisconsin Legislature’s Joint Committee on Finance approved Family Care to move out of its pilot phase, and begin expansion in 2007. By the end of 2018, Family Care will be fully expanded statewide and will continue to provide all Medicaid-covered long-term care services and supports, as well as outpatient behavioral health, to people who qualify for or are at risk of an institutional level of care. Family Care and Family Care Partnership will continue to work to keep members in their homes or in the least restrictive setting for as long as possible.
FIGURE 2

1984
Several southeastern and southwest Counties began using acute care HMOs

1993
Children Come First voluntary Medicaid demonstration program began in Dane County

1994
Voluntary SSI HMO enrollment began

1995
Wisconsin Family Care Partnership began

1997
Acute care HMO expansion nearly statewide for non-SSI Medicaid population

1998
Family Care began

1999
BadgerCare Program began

2007
Family Care expansion began

2008
BadgerCare Plus began (merged Medicaid and Children’s Health Insurance Program)

2014
Care4Kids Prepaid Inpatient Health Plan began in southeast Wisconsin

2018
Family Care achieves statewide expansion
2. **Methods and Process for Development: § 438.202(b)**
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: §§ 438.202(b) and 438.340(c) and (d)**
The draft Quality Strategy document will be made available February 20 through April 21, 2018, for comment by stakeholders and the general public through a number of outreach efforts. This input included advisory committees and councils, tribal consultation, and publication on the DHS website. Following the 60-day public comment period, all feedback will be reviewed and responses will be provided to each discussion point. Appendix 8e will include a summary of comments received on the Quality Strategy, responses provided, and any associated updates to the Quality Strategy. The final version of the Quality Strategy will be available on the DHS website.

b. **Process for Review and Update of the Quality Strategy: §§ 438.202(d) and 438.340(c)**
DMS will review and update the Quality Strategy at a minimum of every three years. If there is a significant change in the interim, as defined by a change in a goal or a strategy, DMS will update the Quality Strategy to reflect this change, solicit public comment, and request CMS approval.

3. **Organizational Goals, Objectives, and Foundational Principles**
DHS has established its mission, visions, and values. As a division of DHS, DMS has established its own quality domains, goals, objectives, and foundational principles to support the DHS mission and guiding principles. These components are described in the following section.
a. DHS Mission, Vision, and Values

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

**Vision:** Everyone living their best life.

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

b. DMS Mission, Vision, Values

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

**Vision:** People empowered to realize their full potential.

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

c. Foundational Principles

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

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

- **Access:** Empower people with access to an array of services and supports. Ensuring member access to care drives decision-making in our program management.

- **Choice:** Engage people to make meaningful choices about where and with whom they live, and their services and who provides them. Consider member preferences, health and social needs, person-centered care, and member engagement when making decisions about DMS programs and initiatives.

- **Use data to evaluate programs and inform decision making:** Use data to evaluate and make timely decisions about policies, strategies, programs, and infrastructure needs.

- **High-quality:** Ensure continuous improvement of high-quality programs to achieve member’s identified goals and outcomes.

- **Collaboration:** Foster collaborative relationships through robust and transparent communication.

- **Cost–Effective— Be good stewards of Medicaid funds:** Promote efficient and cost-effective services and supports through innovation, standards, data-driven quality, and evidence-based practices. Maximize the value of each dollar spent, as reflected by cost-effectiveness, accountability for the management of contracts, and quality of services provided to Medicaid members.

- **Leadership:** Lead the nation in developing innovative approaches for improving the delivery of acute and long-term care services and supports.

- **Engage:** Provide a workplace with opportunities for staff engagement and personal and professional growth.

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

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

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

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

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

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<td>• Increase the percentage of Family Care and Family Care Partnership subcontractors with standards that are in compliance with provider selection and retention standards set by DMS.</td>
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<td>• Increase the percentage of Family Care and Family Care Partnership members who report living in the setting they prefer.</td>
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</tbody>
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<thead>
<tr>
<th>Health Outcomes and Reducing Disparities</th>
<th>Acute Care</th>
<th>Long-Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 4</strong></td>
<td>Improve health outcomes for BadgerCare Plus and SSI HMO members at the individual and population health levels.</td>
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<tr>
<td><strong>Objectives</strong></td>
<td>• Increase the proportion of BadgerCare Plus and SSI HMO members receiving high-quality care management services.</td>
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<td></td>
<td>• Improve care and treatment for BadgerCare Plus and SSI members with mental health and substance abuse conditions.</td>
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<tr>
<td><strong>Goal 5</strong></td>
<td>Ensure continuous improvement of high-quality programs to achieve the goals and outcomes identified by Family Care and Family Care Partnership members.</td>
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<tr>
<td><strong>Objectives</strong></td>
<td>• Increase the percentage of service plans that address the assessed needs and personal goals of Family Care and Family Care Partnership members.</td>
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<td>• Increase the percentage of Family Care and Family Care-Partnership members for whom services, as identified in the member-centered plan, were implemented consistently with the plan.</td>
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<td>Acute Care</td>
<td>Long-Term Care</td>
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<tr>
<td><strong>Goal 5</strong></td>
<td>Reduce health disparities experienced by BadgerCare Plus and SSI HMO members based on age, race, ethnicity, gender, primary language spoken, disability status, and geographic location.</td>
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**Objectives**
- Reduce health disparities, as reflected in access, quality, and health outcomes, experienced by BadgerCare Plus and SSI HMO members.
- Reduce infant mortality rates among African American BadgerCare Plus and SSI HMO members.


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

a. **Payment Strategies**

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

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

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

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

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

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

iii. Reduce Avoidable, Non-Value Added Care
Public and private payers across the country are increasingly focusing on reducing avoidable care that is not value-added by monitoring measures such as potentially preventable readmission rates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. **Member Engagement and Choice Strategies**

DMS promotes member and family engagement by ensuring they are partners in defining, designing, participating in, and assessing the care practices and systems that serve them to make sure these practices and systems are respectful of and responsive to individual member preferences, needs, and values. This collaborative engagement allows member values to guide all clinical decisions and drives genuine transformation in provider attitudes, behavior, and practice. 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.

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

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

### ii. Long-Term Care Choice Strategy

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

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

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

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

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

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

5. Enabling Infrastructure: Data and Technology

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

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

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

a. Accelerate Quality Monitoring
To support implementation of the strategies outlined in this document and assessment of progress toward goals and objectives, the future data and technology plan will establish a robust electronic quality measurement system. A robust quality monitoring plan, enabled by health information technology, will support all programs by:
• Evaluating if current data systems effectively support programs and strategies and whether they collect relevant and adequate administrative, clinical, and other data from multiple sources.
• Using the statewide Health Information Exchange so that payers and providers can access real-time data to improve care coordination and deliver care, regardless of a member’s location.
• Monitoring and identifying health disparities by collecting and using appropriate member eligibility, enrollment, assessment, and care utilization data.
• Assessing and stratifying long-term care member needs through tools such as the Functional Screen.
• Supporting member engagement by providing an easily accessible public website for quality metrics reporting, and external quality review organization and program evaluation findings, in compliance with the managed care rule.

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

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

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

i. BadgerCare Plus HMOs

| Program Description                                                                 | In 1999, Wisconsin introduced BadgerCare to provide acute, primary, and behavioral health Medicaid services to parents and children. Then in 2008, under a federal demonstration waiver, BadgerCare merged Medicaid (Title XIX of the Social Security Act) with the Children’s Health Insurance Program (Title XXI of the Social Security Act) to become BadgerCare Plus. Through BadgerCare Plus, from 2009 through 2013, the state of Wisconsin extended eligibility to childless adults with income up to 200% of the federal poverty |
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 18 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 (with up to 2.5% upfront withhold), core reporting, and other reporting. Further quality assurance requirements are outlined in Section 6.

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<tr>
<th>Activities and Interventions</th>
<th>Payment strategy:</th>
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<tbody>
<tr>
<td></td>
<td>• Pay-for-performance and core reporting</td>
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<td>• Alternative payment model threshold</td>
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<th>Delivery system and person-centered care strategy:</th>
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<tr>
<td></td>
<td>• Performance improvement projects</td>
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<td>• Potentially preventable readmissions</td>
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<td>• Health needs assessment</td>
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<td>• Care Plans</td>
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<th>Member engagement and choice strategy:</th>
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<td></td>
<td>• Consumer Assessment of Healthcare Providers and Systems for children</td>
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<td></td>
<td>• Public reporting, including website and report cards</td>
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<td>• Prevalent language rules</td>
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| Next Steps                   | DMS will focus on implementing the payment reform strategy in BadgerCare Plus HMOs, through pay-for-performance, advancing an alternative payment methodology threshold requirement, and reducing potentially preventable readmission rates. The BadgerCare Plus HMO program will also increase member engagement initiatives as a strategy to achieve objectives related to member engagement and experience of care. DMS has also submitted an 1115 Waiver[^10] to CMS for childless adults, which would require additional activities and interventions for this population. |

### 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.

Starting in 2018, enrollment in HMOs is mandatory for SSI adult members who live in counties where there are two or more HMOs serving SSI members. Medicaid SSI members who have dual eligibility for Medicaid and Medicare and members who are enrolled in a Medicaid Purchase Plan (MAPP) are not subject to mandatory enrollment. Currently, there are nine SSI HMOs.

Any SSI HMO meeting the network adequacy requirements and additional qualifications can contract with Wisconsin Medicaid to provide services to SSI members. Rates are actuarially sound and set annually by DMS and its actuaries. HMOs are required to participate in pay-for-performance (with up to 2.5% upfront withhold), core reporting, and other reporting. Further quality assurance requirements are outlined in the Quality Assurance Section.

### Activities and Interventions

**Payment strategy:**
- Pay-for-performance and core reporting
- Alternative payment models threshold

**Delivery system and person-centered care strategy:**
- Potentially preventable readmissions
- Performance improvement projects
- Care management initiative – needs assessment and stratification, comprehensive care plan, transitional care processes, and enhanced care coordination, including a Wisconsin interdisciplinary care team structure for members with highest needs

**Member engagement and choice strategy:**
- Public reporting, including website and report cards
- Prevalent language rules

### Next Steps

DMS will implement its acute care delivery system strategy by working with SSI HMOs and the external quality review organization to ensure SSI HMOs achieve compliance with the requirements of the care management model. In 2018, DMS will require all SSI HMOs to undertake a needs stratification performance improvement project to ensure a robust stratification methodology is in place.
This will allow DMS to assess effectiveness in reducing potentially preventable readmissions and to continue refining the structure of this program to achieve best results for members. DMS will identify care management best practices and encourage HMOs to adopt these best practices.

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

iii. Care4Kids Health Home

**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 a choice to enroll their child in a fully coordinated Medicaid medical care system or to have them receive Medicaid fee-for-service benefits. Parents may enroll or unenroll their child at any time.

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.

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### 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.

### 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.

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### Program

The HIV/AIDS Health Home targets individuals with HIV and at least one other diagnosed chronic condition or who are at risk of developing another chronic condition.
The AIDS Resource Center of Wisconsin is the sole AIDS service organization in Wisconsin. It has locations in Milwaukee, Kenosha, Brown, and Dane counties.

In the HIV/AIDS Health Home, AIDS Resource Center of Wisconsin provides comprehensive care coordination for eligible individuals across all health care settings and between health and community care settings. The AIDS Resource Center of Wisconsin has a core team of health care professionals that includes experts in the care and treatment of individuals diagnosed with HIV infection.

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])\(^\text{11}\) 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.

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<tr>
<th>Description</th>
<th>Activities and Interventions</th>
<th>Next Steps</th>
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• 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) | The HIV/AIDS Health Home will continue to implement the delivery system reform strategy by focusing on quality improvement, which will include requiring collection of data and quality measures to set baselines and provide metrics for program performance, and coordination of record reviews by DMS and the DHS Division of Public Health. |

**Obstetrics Medical Home**

The Obstetrics Medical Home launched in January 2011 as a pilot limited to six southeast Wisconsin counties (Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha). In 2014, the program expanded to Dane and Rock counties and became available to SSI members. The program’s objective is to improve birth outcomes and reduce birth disparities among high-risk pregnant women.

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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).

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<th>Delivery system and person-centered care strategy:</th>
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<td>• Patient engagement and assessment to identify needs</td>
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<td>• Patient education</td>
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<td>• Care coordination</td>
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<td>• Complex care management</td>
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<td>• Care plan</td>
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<td>• Discharge planning</td>
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<td>• Coordination with prenatal care coordination (PNCC) benefit</td>
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Member engagement and choice: home visits

| Next Steps | The Obstetrics Medical Home will implement administrative efficiencies and focus on quality improvement to continue implementing the delivery system reform strategy and achieve the objective of improving birth outcomes and reducing birth disparities. |

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 five MCOs to operate Family Care in 70 counties throughout Wisconsin. As of December 2017, Family Care has a total of 46,451 members. Family Care MCOs provide or coordinate cost-effective and flexible services tailored to each member’s needs. DMS provides each Family Care MCO with a monthly payment for each member and the MCO uses these funds to provide and coordinate services for all of its members. Each Family Care member is the essential member of his or her own interdisciplinary care team. The team works directly with the member |

to identify the member’s needs, strengths, preferences, and available resources in order to develop a person-centered plan. The person-centered plan may include help from natural supports (for example: family, friends, neighbors). When a member does not have natural supports available, the Family Care MCO will purchase the necessary services for the member.

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<th>Activities and Interventions</th>
<th>Payment strategy: pay-for-performance</th>
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<td>• Member-centered care plan</td>
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<td>• Care management reviews</td>
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<td>• Independent file review</td>
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<td>• Family Care expansion to Dane and Adams counties</td>
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Member engagement and choice strategy:
• Member satisfaction survey
• Adult long-term care functional screen

<table>
<thead>
<tr>
<th>Next Steps</th>
<th>The Family Care program will continue to focus on quality improvement, including developing additional pay-for-performance initiatives; keeping members healthy, safe, and supported in the community for as long as possible; providing increased support for behavioral health; and supporting community integrated employment.</th>
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<tr>
<td></td>
<td>These activities and interventions, which are and will continue to be implemented in Family Care, are also discussed in the DMS Quality Strategies Section.</td>
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</table>

ii. **Family Care Partnership**

<table>
<thead>
<tr>
<th>Current Program Design</th>
<th>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.</th>
</tr>
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<tr>
<td></td>
<td>Currently, DMS contracts with three MCOs to operate Family Care Partnership in 14 counties throughout Wisconsin. As of December 2017, Family Care Partnership has a total of 3,098 members. Family Care Partnership MCOs provide or coordinate cost-effective and flexible services tailored to each member’s needs. In addition to ensuring each member’s long-term care service needs are met, members enrolled in Family Care Partnership receive their acute and primary care, including Medicare benefits, through the MCO.</td>
</tr>
</tbody>
</table>
DHS provides the MCO with a monthly payment for each member, and the MCO uses these funds to provide and coordinate services for all of its members. Each Family Care Partnership member is the essential member of his or her own interdisciplinary care team. The team works directly with the member to identify the member’s needs, strengths, preferences, and available resources in order to develop a person-centered plan. The person-centered plan may include help from natural supports (for example: family, friends, neighbors). When a member does not have natural supports available, the Family Care Partnership MCO will purchase the necessary services for the member.

<table>
<thead>
<tr>
<th>Activities and Interventions</th>
<th>Payment strategy: pay-for-performance</th>
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<tr>
<td></td>
<td>Delivery system and person-centered care:</td>
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<tr>
<td></td>
<td>• Performance improvement projects</td>
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<td>• Member-centered care plan</td>
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<td>• Care management reviews</td>
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<td>• Independent file review</td>
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<td>• Adult long-term care functional screen</td>
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</table>

| Next Steps                  | The Family Care Partnership program will continue to focus on quality improvement, including developing additional pay-for-performance initiatives; keeping members healthy, safe, and supported in the community for as long as possible; providing more support for behavioral health; and supporting community integrated employment. |
|                            | 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. |

6. Quality Assurance
This section describes how DMS complies with federal Medicaid managed care rule requirements in § 438.204.

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

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

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

   The network adequacy standards determined by DMS encompass member enrollment, utilization of services, member target groups, and health care needs. The MCOs are also required to include network providers that are culturally competent, are able to communicate with members with limited English proficiency in their preferred language, and can ensure physical access and reasonable accommodations. DMS is working with MCOs to develop innovative technological solutions, including telemedicine and e-visits. Within their policies, administration, provider contracts, and service practices, each MCO is required to incorporate the values of honoring each member’s beliefs, being sensitive to cultural diversity, and fostering staff and provider attitudes and interpersonal communication styles that respect each member’s cultural background.
As of January 1, 2018, all providers that contract with and serve MCO members will be enrolled with the state pursuant to the 21st Century Cures Act of 2016.\textsuperscript{12}

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

i. Evidence-Based Clinical Practice Guidelines

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

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

ii. Members With Special Needs

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

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

iii. Transitions of Care Policy

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

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

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

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

Changes to the enrollment process and to the Medicaid Management Information System are underway. The changes will enhance the collection and use of demographic data for identifying and reducing health disparities. At least annually, collected demographic data will be analyzed by the DMS quality team to identify and monitor health disparities. Current interventions to address health disparities and assess members for social determinants of health include community referrals in care plan development, the Obstetric Medical Home, the HIV/AIDS Medical Home, and a DMS-wide cultural competency committee. The DMS quality team will engage in a plan, do, study, act process to evaluate current interventions, set future reduction goals, plan and implement future interventions to reduce health disparities, evaluate current interventions, set future reduction goals, and further refine and facilitate ongoing interventions to continue to address health disparities.
As part of the health disparity reduction efforts, and pursuant to § 438.340, DMS shares member demographic information with BadgerCare Plus and SSI HMOs. Long-term care MCOs receive functional screen information, which includes race, ethnicity, and disability status. Long-term care program staff publish the long-term care scorecard and enrollment numbers, which delineate between target groups. A member’s age, gender, primary language data, and disability status is transmitted to BadgerCare Plus and SSI HMOs each month. DMS is working to include race and ethnicity demographic data as part of data shared with BadgerCare Plus and SSI HMOs to fully meet the requirements in § 438.340. DMS collaborates with the DHS Division of Public Health on data collection and initiatives related to reducing health disparities in the state.

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

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

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

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

- Maintain documentation of the following activities of the quality management program and have that documentation available for DMS review upon request:
  - The annual quality management work plan and its approval by the governing board or designee.
  - Monitoring the quality of assessments and member-centered care plans.
  - Monitoring the completeness and accuracy of completed functional screens.
  - Monitoring the results of care management practice related to the support provided to vulnerable/high-risk members.
  - Member satisfaction surveys.
  - Provider surveys.
  - Incident management systems.
• Appeals and grievances that were resolved as requested by the members.
• Monitoring of access to providers and verifying that the services were actually provided
• Performance improvement projects.
• Results of the annual evaluation of the quality management program.
• Monitoring the quality of sub-contractor services as noted in Article I.XVI.G.5.,
  Contractual Relationship.
• Restrictive measures
• Performance improvement projects
• Create and approve an annual quality management work plan and evaluation.
• Maintain a health information system that collects, analyzes, integrates, and reports data
  that can support the objectives of the MCO’s quality management program.

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

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

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

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

i. Performance Improvement Projects

**Acute care:** Article X of the BadgerCare Plus and SSI HMO contract requires HMOs to have
performance improvement projects to address the specific needs of the population enrolled in
the HMO. All BadgerCare Plus and SSI HMOs are required to submit two performance
improvement projects each year. HMOs that only serve the BadgerCare Plus population are
required to submit PIP proposals on two different topics. HMOs that serve only the SSI
population are required to submit one performance improvement project proposal for 2018 on SSI care management and one performance improvement project on another topic. HMOs that serve both BadgerCare Plus and SSI are required to submit one performance improvement project for each population. The specific requirements of the performance improvement projects are described within the HMO quality guide and within Article X of the Badger Care Plus and SSI HMO contract.

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

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

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

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

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

**Acute care:** DMS works with the external quality review organization on quality monitoring activities, including performance measurement validation of pay-for-performance and core reporting measures, performance improvement project review, and comprehensive reviews of
federal managed care and contract requirements. Beyond the mandatory activities, the external quality review organization validates SSI HMO care management performance, compliance with the health needs assessment requirements for childless adults, and compliance with the Obstetrics Medical Home program requirements.

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

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

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

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

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

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

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

The detailed accreditation crosswalk, list of National Committee of Quality Assurance-accredited BadgerCare Plus and SSI HMOs, and additional information about the accreditation deeming process will be detailed publicly on the ForwardHealth 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.

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

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021+</th>
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<tbody>
<tr>
<td>Access to Care and Member Choice</td>
<td>Implement SSI managed care program expansion</td>
<td>Further provider network standards development, External Quality Review Organization validation</td>
<td>SSI managed care program expansion: continued implementation, evaluation and improvement</td>
<td></td>
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<tr>
<td>Cost Effectiveness</td>
<td>Implement alternative payment models threshold requirement</td>
<td>Implement potentially preventable readmissions alternative payment models</td>
<td>Alternative payment models: continued implementation, evaluation, and improvement</td>
<td>Potentially preventable readmissions alternative payment models: continued implementation, evaluation, and improving</td>
</tr>
<tr>
<td>Patient-Centered Care and Member Experience</td>
<td>Care coordination initiative for SSI managed care program expansion: implement, continue evaluation and improvement</td>
<td>Quality data for public on web</td>
<td>Provide focused care through health homes for special needs populations</td>
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<tr>
<td>Infrastructure and Data and Technology</td>
<td>DHS cultural competence committee and HMO Culturally and Linguistically Appropriate Services (CLAS) self-assessment</td>
<td>Design/continuous evaluation and improvement – health homes, centers of excellence, SSI care management, value-based purchasing, health needs assessment, etc.</td>
<td>Implement measurement and improvement initiatives for key health disparities</td>
<td>Disparity reduction initiatives: continue implementation, evaluation, and improvement</td>
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<td></td>
<td>Capture demographic data and create baselines for Medicaid health disparities</td>
<td>Explore SSI care management super utilizers program</td>
<td>Pay-for-performance, health needs assessment, core reporting, and HMO report cards</td>
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<tr>
<td></td>
<td>Planning for data infrastructure</td>
<td>Implement data and technology plan recommendations</td>
<td>Medicaid Management Information System module procurement and implementation</td>
<td>Health information exchange promotion</td>
</tr>
</tbody>
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b. Long-Term Care

| 2018 | 2019 | 2020 | 2021+
|------|------|------|------
| Family Care/Family Care Partnership scorecard development and pilot | Family Care/Family Care Partnership scorecard implementation |  |  |
| Adult long-term care member satisfaction survey redesign | Adult long-term care member satisfaction survey |  |  |
| Provider network adequacy and enrollment (SharePoint repository site, MCO engagement, ongoing monitoring and compliance) |  |  |  |
| Pay-for-performance: member satisfaction survey | Pay-for-performance: continued implementation, evaluation, and improvement |  |  |
| External Quality Review Organization/annual quality review improvement implementation | Incident management system: dashboard, immediate reportable tracking and communication between DMS and MCO |  |  |
| Assuring member health and safety: streamlining restrictive measure process, restrictive measures system design | Assuring member health and safety: implementation of restrictive measures system |  |  |
| DHS cultural competence committee | National Care Indicators |  |  |
| Implement measurement and improvement initiatives for key health disparities | Disparity reduction initiatives: continue implementation, evaluation, and improvement |  |  |
| Data infrastructure using enterprise system (information exchange system) | Medicaid Management Information System module procurement and implementation |  |  |
| • Restrictive measures system | • Home and community based services data |  |  |
| • Incident management system | • Institutions for mental health data |  |  |
8. Appendices

a. Quality Framework

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

The quality framework includes 13 domains listed and described below:

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

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

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

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

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

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

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

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

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

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

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

**Care management:** Care management refers to a group of integrated activities, tailored for an individual member, designed to effectively manage medical, social, and mental or behavioral health conditions. Care management programs are typically led by primary care professionals and focus on patients with chronic, high-cost conditions, such as heart disease, diabetes and
cancer, as well as those with complicated pregnancies, trauma, or other acute medical conditions, and may also address social determinants of health.

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

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

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

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

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

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

Division of Medicaid Service (DMS): DMS is a division within DHS that supports Wisconsin’s Medicaid programs. DMS provides access to health care, long-term care, and nutritional assistance to more than one million Wisconsin residents who are elderly, disabled, or have low income. DMS administers Medicaid programs to medically needy and low-income individuals and families, as well as long-term care, support, and services for older adults, and services for people of all ages with disabilities. DMS administers other programs such as FoodShare, state-funded SSI program benefits, as well as Medicaid-funded subprograms, including primary and acute care services, Medicaid reimbursement to nursing homes, BadgerCare Plus, SeniorCare,
Family Care, Family Care Partnership, IRIS (Include, Respect, I Self-Direct), and children's long-term care services. DMS also includes the Disability Determination Bureau, which administers the federal Social Security Administration and Medicaid disability determination; and Milwaukee Enrollment Services, which administers income maintenance services for Milwaukee County.

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

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

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

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

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

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

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

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

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care and follow-up
• Patient and family support
• Referral to community and social support services

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

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

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

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

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

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

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

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

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

**Interdisciplinary care team:** A team that consists of, at a minimum, a social worker or a care manager and a registered nurse. With the consumer and his or her representative (if any), other professionals (as appropriate) also participate as members of the interdisciplinary team. The interdisciplinary team conducts a comprehensive assessment of the member’s needs,
abilities, preferences, and values. The assessment looks at areas such as activities of daily living, physical health, nutrition, autonomy and self-determination, communication, and mental health and cognition.

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

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

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

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

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

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

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

**Medical home**: A medical home is a care model that involves the coordinating a member's overall health care needs, similar to a health home, but it is not focused on a particular chronic condition.
Medicare: Medicare is the federal health insurance program, authorized by Title XVIII of the Social Security Act that covers people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease.

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

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

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

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

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

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

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

- Performance measurement
- Incentive design
- Transparency and consumer engagement
**Performance target:** A performance target is a specific, planned level of a result to be achieved within an explicit timeframe with a given level of resources.

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

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

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

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

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

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

**Program:** In this document, programs refers to the health and long-term care programs serving particular Wisconsin Medicaid members through managed care, including BadgerCare Plus, Medicaid SSI, Family Care, and Family Care Partnership.
**Quality**: Quality is defined as how well the health plan keeps its members healthy or treats them when they are sick. Quality health care means doing the right thing at the right time, in the right way, for the right person, and getting the best possible results.

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

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

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

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

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

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

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

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

**Supplemental Security Income (SSI)**: SSI refers to eligible individuals receiving income through federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind, or have a disability and have household income levels at or below 100% of the federal poverty
level. Individuals receiving SSI may receive health care services through Medicaid SSI or SSI-Related Medicaid.

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

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

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

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

**Wisconsin Medicaid Quality Strategy (Quality Strategy):** The Quality Strategy document complies with federal regulations (§ 438, subpart D) and is intended to serve as a framework for the state and its contracted health plans to assess the quality of care that members receive, as well as set measurable goals and targets for improvement.
c. Quality Measure Matrix
The specific quality measures, listed below, are from reference materials linked in Appendix 8g.

i. Acute Care
Pay-for-performance measures for BadgerCare Plus and SSI HMOs:

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

Core reporting measures for BadgerCare Plus HMOs:

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

Core Reporting Measures for SSI HMOs:

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

SSI Care Management Initiative Measures:

- Care Planning (CP1): percentage of new members had a care plan within 90 days of enrollment
• Needs Stratification (NS1): percentage of members enrolled each month assigned to WICT
• Needs Stratification (NS2): percentage of members enrolled over the year assigned to WICT
• Needs Stratification (NS3): average number of months a member assigned to WICT
• Needs Stratification (NS4): percentage of members enrolled each month assigned to Medium stratum
• Needs Stratification (NS5): percentage of members enrolled over the year assigned to Medium stratum
• Needs Stratification (NS6): percentage of members enrolled each month assigned to Low stratum (equal to combining all strata below Medium)
• Needs Stratification (NS7): percentage of members enrolled over the year assigned to Low stratum (equal to combining all strata below Medium)
• Transition Care (TC1): percentage of discharges who received transition care follow-up
• Transition Care (TC2): percentage of discharges who received transition care follow-up within five days

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

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

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

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

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

Long-term care in motion measures:
• Enrollment by target group
• Target group enrollment by program
• Enrollment by age
• Enrollment by age, by program
• Current living situation
• Current living situation by program
• Service expenditures by program
• Percentage of member self-directed services by program
• Employment for working age members (18-64)
- Percentage of members receiving influenza vaccine
- Percentage of members receiving pneumonia vaccine

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

External quality review annual technical report measures
- Validates quality compliance review
- Validates performance improvement projects
- Validates performance measures
- Information systems capability assessment
- Care management review
d. Summary of Current Enabling Data and Technology Assets
Currently, data and infrastructure technology enabling acute care and long-term care managers and program areas include:

- **Encounters and claims**: BadgerCare Plus and SSI HMOs and Care4Kids must submit compliant encounter data files in a HIPAA compliant ASC X12 transaction format. To do so, they must have a system that is capable of processing claims, submitting compliant encounters, monitoring enrollment and disenrollment, and reporting requirements.

- **Member and provider enrollment**: BadgerCare Plus and SSI HMOs must submit a detailed provider network and facility file, and must use only those providers that have been enrolled with Wisconsin Medicaid. All members in Family Care and Family Care Partnership are enrolled through the state. To qualify for Family Care and Family Care Partnership, the participant must meet both functional and financial requirements. DHS maintains all data on each member enrolled in the program that are collected through the state interChange (Medicaid Management Information System) system, encounter data, and the functional screen.

- **Surveys**: The acute care program area collects periodic information from BadgerCare Plus and SSI HMOs through surveys and uses the CAHPS Survey for members (see DMS Managed Care Programs section). Family Care and Family Care Partnership collect information through the use of an annual member satisfaction survey through an impartial third party.

- **Public and private registries**: The BadgerCare Plus HMOs, SSI HMOs, and Obstetrics Health Home have a self-developed registry, hosted by the external quality review organization, to share information between HMOs, clinics, and DMS acute care program staff.

- **Stakeholder-reported data**: Acute care program staff collect health care effectiveness data and information set-audited measures from HMOs, as well as periodic written reporting and performance data for various programs.

- **ACCESS**: ACCESS is a self-service internet-based application that allows the public to enroll in public assistance programs, including Medicaid, BadgerCare Plus, FoodShare, Child Care, and W-2. ACCESS includes functionality that allows members to screen for benefit eligibility, apply for benefits, check the status of benefits, report a change, renew benefits, and submit documentation. It is available online to citizens 24 hours per day, seven days per week. The ACCESS portal includes the functional screen for long-term care members.

- **Client Assistance for Re-employment and Economic Support System (CARES)**: Wisconsin’s highly integrated system that uniquely identifies individuals and efficiently shares data across multiple eligibility programs and work programs. The Wisconsin CARES system enables workers in all Wisconsin counties and tribes the ability to perform automated eligibility determination, benefit calculation, and case management for applicants applying for Medicaid (including long-term care and SeniorCare prescription drug program), BadgerCare Plus, FoodShare, Child Care Assistance, TANF, and Caretaker Supplement program.
• **Adult long term care functional screen:** This system is a web-based application used to collect information about an individual’s functional status, health, and need for assistance for various programs that serve the frail elderly, people with intellectual/developmental disabilities or physical disabilities. Wisconsin’s functional screen system was developed using web-based technology and it determines functional eligibility for adult long-term care waiver programs. Experienced professionals, usually licensed social workers or registered nurses who have taken an online training course and passed a certification exam, are able to access and administer the functional screen. The functional screen is completed when someone applies for long-term care services and annually once they are receiving services. The functional screen is also used to establish capitated rate payments annually for MCOs.

• **Medicaid Management Information System:** The ForwardHealth interChange2 is Wisconsin’s multi-payer, web-based Medicaid Management Information System. This system provides claims processing, payment and reporting, provider and managed care enrollment information, coordination of benefits, and other administrative and operational system support to Wisconsin's health care programs, including Medicaid, BadgerCare Plus, Family Care, SeniorCare, Wisconsin Immunization Registry, Wisconsin Well Woman Program, and Wisconsin Chronic Disease Program. ForwardHealth interChange2 was developed using a business model that aligns with the Medicaid Information Technology Architecture Framework.

• **ForwardHealth:** The ForwardHealth Portal uses secure web portal technology to serve providers, managed care organizations, trading partners, and other partners. It provides access to interChange2, depending on the type of user and the user’s specific role. The secure portal allows users to securely conduct business with ForwardHealth as listed below for each user type:
  o 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.
  o The primary areas covered under the secure **MCO portal** include: portal messaging, enrollment verification, interChange2 (iC2) functionality, remittance advice, electronic funds transfer, designation of an 834/820 receiver, and trade files and reports.
  o 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.
  o The primary areas covered under the secure **partner portal** include: portal messaging, enrollment verification, and interChange2 (iC2) functionality.

• **Electronic health records and patient portals:** Most contracted acute care providers use electronic health records to document health information in digital formats. Provider portals can be connected to electronic health records for acute personal health information and to communicate with providers. Electronic health records systems can also be patient
portals used by health plans to connect with members for billing, care alerts, and other purposes.

- **Care coordination software**: Most BadgerCare Plus and SSI HMOs have technology to help document care coordination and member care plans; however, this software varies by HMO. All Family Care and Family Care Partnership MCOs have and maintain care coordination software to document care provided and to maintain the current member-centered plan. The software varies by MCO.

- **MCO management information system**: Each long-term care MCO must maintain a health information system that collects, analyzes, integrates, and reports data on utilization, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility.

- **Information exchange system**: Long-term care MCOs report data, as requested by DMS, through the information exchange system. In addition to encounter reporting, uses of this system include incident reporting and restrictive measures reporting.

- **Secure file transfer and secure portal**: BadgerCare Plus and SSI HMOs must have a secure ForwardHealth Portal account to access data and reports, maintain information, conduct financial transactions, and other business with acute care program staff.
The draft Quality Strategy document will be made available February 20 through April 21, 2018, for comment by stakeholders and the general public through a number of outreach efforts. This input included advisory committees and councils, tribal consultation, and publication on the DHS website. Following the 60-day public comment period, all feedback will be reviewed and responses will be provided to each discussion point. This appendix will include a summary of comments received on the Quality Strategy, responses provided, and any associated updates to the Quality Strategy.
f. Accreditation Plan
The accreditation plan will be included in the final quality strategy.
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:

BadgerCare Plus and SSI HMO Quality Guide: Link Pending

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