Medicaid Managed Care Quality Strategy 2025-2027

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Introduction

Under 42 C.F.R. § 438.340(a) and 42 C.F.R. § 457.1240(e), the Centers for Medicare and Medicaid Services (CMS) requires that state Medicaid and Community Health Improvement Plan (CHIP) managed care programs develop and maintain a Medicaid and CHIP quality strategy to assess and improve the quality of healthcare and services managed care plans provide.

The Wisconsin Department of Health Services (DHS), Division of Medicaid Services (DMS), has broad quality priorities 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
- Employing principles of evidence-based continuous quality improvement.

The purpose of Wisconsin Medicaid's Managed Care Quality Strategy (Quality Strategy) is to describe population health and quality improvement priorities, oversight efforts, and goals and objectives to make progress in the Wisconsin DMS programs. The Quality Strategy is part of Wisconsin's quality assurance and performance improvement approach to align programs to best meet the health care and service needs of Medicaid members. This Quality Strategy sets a three-year vision for DMS to achieve its quality goals and objectives and is intended to evolve over time. The Quality Strategy covers calendar years 2025 through 2027, using baseline data from years 2018 through 2024.

DMS intends to update the quality strategy every three years, with the next update scheduled for January 2028. The Quality Strategy will be updated in the event of any significant changes, including but not limited to, adding or removing goals or objectives, incorporating changes suggested through public comment, tribal consultation, or the Wisconsin Medicaid Advisory Committee, and substantive changes to managed care laws and regulations during the period this strategy is designed to cover.

DMS's programs help expand coverage and/or targeted benefits to certain participants who would otherwise be without health insurance or access to benefits tailored to their specific medical needs. DMS has three programs that are part of the Quality Strategy. There are additional programs referenced, such as IRIS (Include, Respect, I Self-Direct) and PACE (Program of All-Inclusive Care for the Elderly) but are not in scope for the Quality Strategy. Details of each program are provided in Tables 1, 2, 3:

- Acute and primary health care services for managed care members are provided by BadgerCare Plus (BC+) and Supplemental Security Income (SSI) health maintenance organizations (HMOs).
- Long-term care services for managed care members (for example, managed long-term care services and supports) are provided by Family Care and Family Care Partnership (Partnership) long-term care managed care organizations (MCOs), also referred to as prepaid inpatient health plans (PIHPs). The Partnership program also covers acute and primary care services.
- Care4Kids is an acute and primary health care managed care program with one PIHP serving youth in out-of-home care in six southeastern counties. Wisconsin has a combined Medicaid and Children's Health Insurance Program (CHIP), and members may be enrolled in HMOs or in Care4Kids PIHP, so this Quality Strategy reflects both the Medicaid and CHIP managed care programs.

Although there is alignment and substantial overlap between acute care and long-term care program goals, objectives, and strategies, some divergence is necessary to address the specific needs of the members served by each program. This document is organized to reflect these similarities and differences.

This document was prepared by DMS, the division responsible for overseeing Medicaid programs. Definitions for commonly used terms in the Quality Strategy can be found in the glossary in the Appendix of this document.

Table 1: BadgerCare Plus and SSI Managed Care Organizations, Authorities, and Covered Populations

Program Name	Managed Care Entity Type	Managed Care Authority	Managed Care Program Type
BadgerCare Plus (BC+) SSI	Health Maintenance Organizations (HMOs)	Section 1932(a) of the Social Security Act	Combined Medicaid and CHIP
Contracted Managed Care Organizations		**Populations Covered by BadgerCare Plus and SSI HMOs**	
• Anthem Blue Cross Blue Shield • Chorus Community Health Plans • Dean Health Plan • Group Health Cooperative of Eau Claire • Group Health Cooperative of South Central • Independent Care Health Plan • MHS Health Wisconsin • MercyCare Insurance Company • Molina Healthcare • Network Health Plan • Quartz • Security Health Plan • UnitedHealthcare Community Plan		BC+ HMOs • Parents and caretakers with incomes at or below 100 percent of the Federal Poverty Level (FPL). • Pregnant members with incomes at or below 300 percent of FPL. • Children (ages 18 and younger) with household incomes at or below 300 percent of the FPL. • Childless adults with incomes at or below 100 percent of the FPL. • Transitional medical assistance individuals, also known as members on extensions, with incomes over 100 percent of the FPL. SSI HMO • Are age 65 or older, blind, or disabled; • Have family income at or below the monthly program limit; and • Are U.S. citizens or legal immigrants.	

Program Information	Covered Services
• BC+ and Medicaid SSI HMO program information (for HMOs and providers) • BC+ HMO program information (for members) • Medicaid SSI HMO program information (for members) • HMO Contracts (for providers)	• BC+ program: Covered Services and Copays • SSI program: Covered Services and Copays • BC+ HMO Guide • SSI HMO Guide There are some services that HMOs do not provide. These services are instead provided through fee-for-service coverage. This means HMO members can get these services from any doctor or provider that accepts BC+ or SSI. These services include: • Behavioral treatment services, including treatment for autism spectrum disorder • Chiropractic services • County-based mental health programs including community recovery services, community support program benefits, and crisis intervention services • Dental services in counties other than Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha • Pharmacy services, such as prescription drugs and diabetic supplies • Prenatal care coordination services • Residential substance use disorder treatment • School-based services, such as audiology, physical therapy, and speech therapy supplied by a school • Transportation to and from covered services • Tuberculosis treatment

Table 2: Family Care and Partnership Managed Care Organizations (Partnership), Authorities, and Covered Populations

Program Name	Managed Care Entity Type	Managed Care Authority	Managed Care Program Type
Family Care Partnership	Managed Care Organizations, (MCO) Prepaid Inpatient Health Plans (PIHP)	1915(b) of the Social Security Act	Medicaid
Contracted Managed Care Organizations		**Populations Covered by Family Care and Partnership MCOs**	
Family Care • Community Care, Inc. • Lakeland Care, Inc. • Inclusa, Inc. • My Choice Wisconsin Partnership • Community Care Health Plan • Independent Care (iCare) Health Plan • My Choice Wisconsin Health Plan		Family Care • Individual 18 years old or older • Frail elder or an adult with a disability • Financially eligible for full-benefit Medicaid • Functionally eligible for Family Care as assessed through the Long-Term Care Functional Screen • Have a long-term care condition that will last more than 90 days Partnership • Individual 18 years old or older • Frail elder or an adult with a disability • Financially eligible for Medicaid • Functionally eligible for Partnership as assessed through the Long-Term Care Functional Screen • Have a long-term care condition that will last more than 90 days • Live in a county that offers Partnership	
Program Information		**Covered Services**	
• Family Care program information • Partnership program information • Family Care, Family Care Partnership and PACE: MCO contracts		Benefit information: Family Care offers long-term care services to its members. Services can range from help with daily tasks at home to mental health. Learn more about Family Care benefits. Partnership offers both services covered by Family Care and Medicaid card services for long-term care. Learn more about services included in Partnership MCOs.	

Table 3: Care4Kids Managed Care Organizations/PIHP, Authorities, and Covered Populations

Program Name	Managed Care Entity Type	Managed Care Authority	Managed Care Program Type
Care4Kids (C4K)	Prepaid Inpatient Health Plan (PIHP)	Section 1937 of the Social Security Act	Combined Medicaid and CHIP
Contracted Managed Care Organizations		**Populations Covered by Care4Kids MCOs**	

Chorus Community Health Plan, Inc. (CCHP)		• Children in out-of-home care who reside in Milwaukee, Kenosha, Ozaukee, Racine, Washington, or Waukesha County
		• Children may remain enrolled in Care4Kids for up to 12 months following discharge from out-of-home care when they are also:
		  ○ Eligible for Medicaid; and
		  ○ Reside in Milwaukee, Kenosha, Ozaukee, Racine, Washington, or Waukesha County.	

Program Information		**Covered Services**	
Care4Kids program information		• Care4Kids PIHP contract • ForwardHealth website Care4Kids has many benefits. These include: • Health care coordination • All Medicaid-covered benefits • Dental and vision care There are some services that the PIHP does not provide. These services are instead provided through fee-for-service coverage. This means PIHP members can get these services from any doctor or provider that is a registered Medicaid provider. These services include: • Behavioral treatment services, including treatment for autism spectrum disorder • Chiropractic services	

	• Community recovery services (CRS), community support program, (CSP), comprehensive community services (CCS) and crisis intervention services • Pharmacy services, such as prescription and over the counter drugs and diabetic supplies • School-based services, such as audiology, physical therapy, and speech therapy, identified in a student's individualized education plan (IEP) and provided by a school district or cooperative education service agency (CESA). • Targeted Case Management (TCM) • Non-emergency medical transportation (NEMT) • Certain tuberculosis related services • Prenatal care coordination (PNCC) • Hub and Spoke Integrated Recovery Support Services Health Home for Substance Use Disorder (SUD) Treatment pilot program.

Effectiveness of the Previous Quality Strategy

MetaStar, Inc. is the External Quality Review Organization (EQRO) for DMS. For more information about their role in quality assurance and performance improvement of Wisconsin's managed care programs, see the section of this document called "External Quality Review Arrangements." Upon completion of each year's managed care reviews, the EQRO publishes an annual technical report for DMS which includes recommendations, which are used by DMS to inform changes to the programs or initiatives on an annual basis as well as to inform the development of each Managed Care Quality Strategy. These reports are also available for each managed care plan to improve quality in their service delivery. Within the EQRO's annual technical reports, there is an effectiveness evaluations of each managed care program activity. These annual technical reports are available at:

- Family Care, Partnership, and PACE
- BC+, Medical Homes, Prepaid Inpatient Health Plans, and Medicaid Supplemental Security Income Managed Care

Goals and Objectives

Goals and objectives were identified to support continuous improvement and evaluation of ongoing effectiveness of the Quality Strategy. These goals and objectives for managed care align with the DHS vision, mission, and values. Each objective has performance measures with additional data about the baseline and improvement targets, which can be found in "Quality Metrics and Performance Targets" section of this document.

Goal 1: Improve member health and social connectedness as measured by aggregate performance on specified priority measures.

Objective 1*:* Increase the number of Medicaid Healthcare Effectiveness Data and Information Set (HEDIS®) measures in the Adult and Child Core Sets that meet or exceed the National Committee for Quality Assurance (NCQA) National Medicaid HEDIS median (50th percentile in Quality Compass®) by measure year (MY) 2027.

Objective 2: Improve health outcomes for Wisconsin Medicaid members living with chronic conditions by establishing a target of the 75th percentile nationally for HEDIS measures for chronic health conditions and increase the percentage of SSI members who receive transition care within 5 days following a hospitalization by MY 2027.

a) For children, including members of Care4Kids, DMS will focus on asthma management. Asthma is a leading medical cause of school-based absence and often leads to avoidable emergency department visits.[1]

b) For adults, DMS will focus on diabetes management and the reduction of cardiovascular disease, including treatment of hypertension. Cardiovascular disease is the number one killer in the United States, with improvement stymied by significant health disparities.[2]

Objective 3: Improve population health through increased preventive care and primary care for all members by MY 2027.

Research demonstrates improved health outcomes are reached by populations who have regular engagement with primary care. Restoring and exceeding pre-pandemic levels of primary care utilization will facilitate both the care of chronic conditions and preventive care. We will partner with other ongoing efforts and interested parties in the state such as the Wisconsin Collaborative for Healthcare Quality, the WI Cancer Collaborative, and health care companies working to prevent cancer.

No child should ever suffer from lead poisoning in our state. We will continue to grow our recent collaborations with BC+ HMOs and the Division of Public Health to make sure that all children are screened for lead poisoning at appropriate intervals. A successful collaboration with the Division of Public Health and Care4Kids has led to enhanced blood lead screening requirements for children enrolled in the program.

a) Improve BC+ HMO members' utilization of primary care and preventive services, including periodic well-check visits (HealthCheck), immunizations, colon and breast cancer screenings, enhanced schedule of lead screenings, and dental care.

b) Increase the percentage of Family Care and Partnership MCO members who receive flu vaccinations by 3% each year and pneumococcal vaccinations by 1% each year, over the 2023 baseline.

c) Improve Care4Kids PIHP members' utilization of primary care and preventative services, including periodic well-check visits (HealthCheck); enhanced schedule of lead screenings; and expanded efforts to complete vaccines by age two, behavioral health screenings, and dental care.

[1] Zahran, H. S., Bailey, C. M., Damon, S. A., Garbe, P. L., & Breysse, P. N. (2018). Vital Signs: Asthma in Children – United States, 2001-2016. Centers for Disease Control and Prevention.

[2] Kyalwazi, A.N., Loccoh, E.C., Brewer, L.C., Ofili, E.O., Xu, J., Song, Y., Joynt Maddox, K.E., Yeh, R.W., & Wadhera, R.K. Disparities in Cardiovascular Mortality Between Black and White Adults in the United States, 1999 to 2019. Circulation; 146(3): 211-228.

Objective 4: Increase overall health, safety, and social connectedness of members receiving long-term supports and services by MY 2027.

a) Family Care and Partnership MCOs will increase care coordination by increasing timely follow up/monitoring to verify authorized services and supports were received by members. By 2027, timely follow-up/monitoring will increase to 70%.

b) Family Care and Partnership members will report increased rates of positive levels of satisfaction with the number of opportunities to participate in social activities (2023 baseline satisfaction survey score on a 5-point scale: FC: 3.6 and Partnership: 3.5).

c) Each Family Care and Partnership MCO will increase the percentage of members aged 18-66 who are working in Competitive Integrated Employment settings by 3% annually over their previous year baselines.

d) Achieve 10,000 individuals statewide who have completed Certified Direct Care Professional (CDCP) program by 2027. Achieve 1,500 MCO providers or agencies statewide participating in the CDCP program by 2027. Increasing training and capacity within the direct care workforce will have a positive impact on member health and safety.

Objective 5: Increase utilization of outpatient, least-restrictive behavioral health and substance use disorder services by MY 2027.

People with substance use disorders (SUD) have historically experienced health disparities due to bias and exclusion, including systemic racism. DMS prioritizes proper access to behavioral health and SUD treatment and services that meet individual needs in the least restrictive manner possible. Proactive treatment and services have a positive impact on individual outcomes. As behavioral health and SUD treatment needs increase across Wisconsin, and there are workforce shortages for specialists in these professions, ensuring proper access to equitable care is more important than ever.

Increasing early and timely interventions and connection to services after a crisis or inpatient stay can decrease the need for future stays. Admission into inpatient treatment can be costly and disruptive for patients and their families. Admissions and readmissions can lead to disruptions in the lives of individuals and may be due to ineffective care, lack of outpatient care, or community resources. DMS aims to increase proactive treatment and services within the community and decrease the need for inpatient and restrictive measures that are disruptive and interfere with an individual's independence and rights.

a) Improve treatment for mental health and substance use disorders. Increase early identification, timely intervention, and timely follow-up care after an emergency department visit or in-patient stays for a mental health disorder by MY 2027.

b) Reduce the number of restrictive measures applications for individuals with behavioral health needs in Family Care and Partnership by 3% over the next 3 years (or 1% per year over the next 3 years).

c) Reduce the number of Family Care members who are admitted to institutions for mental disease (IMDs) multiple times in a calendar year by 7% over the next 3 years. Baseline: In 2023, 25.5% of Family Care members that were admitted to an IMD were readmitted at least once in the same year.

Goal 2: Reduce health disparities and support underserved populations by providing person-centered services and supports.

DMS recognizes that improving health equity is a foundational strategy for improving the health of Wisconsin's residents and improving the experience of care for Wisconsinites. Persistent and systematic differences in health outcomes for different Wisconsin populations are well

documented, and a key component of Healthiest Wisconsin 2026. Health disparities are often related to the conditions in which people are born, live, grow, work, and age – also called the social determinants of health (SDOH). Economic resources and geographical location have a proven sizable impact on health outcomes. Partnerships between communities and the health care system are critical for improving health across the lifespan and reducing disparities in health outcomes.

Objective 1: By MY 2027, address members' Health-Related Social Needs (HRSNs) identified through screening by ensuring they receive a corresponding intervention. Every managed care member is screened at least once annually for HRSNs, and each managed care program has established policies and procedures for addressing identified HRSN needs.

a) Establish a target of the 75th percentile nationally for BC+ and SSI HMO performance on the HEDIS Social Need Screening and Intervention (SNS-E) measure.[3] SNS-E measures the percentage of members who were screened for unmet needs related to food, housing, and transportation and who received a corresponding intervention within 30 days of a positive screen.

b) Family Care and Partnership MCOs will increase the percentage of member-centered service plans that are comprehensive by properly addressing members' assessed needs and personal goals by MY 2027.

c) Care4Kids PIHP will increase the percentage of unique member needs and services addressed through timely follow-up by 8% over the 2023 baseline by MY 2027.

Objective 2: Improve healthy birth outcomes by increasing utilization of certain maternity services, by reducing rates of babies with low birth weights, and by reducing rates of C-section utilization, while also reducing racial and ethnic disparities in these measures, by MY 2027.

Maternal mortality and morbidity in the nation have risen to unacceptable levels, while significant disparities persist in the outcomes for both pregnant people and infants in our state. To achieve improved pregnancy and birth outcomes, members must be able to access care providers that they trust throughout the perinatal period. Through continued development of our initiatives and engagement of provider groups, HMOs, Division of Public Health, and the WI Perinatal Quality Collaborative, we will ensure that members work with birth providers that are well-trained, provide culturally relevant care, have experience working with people of different communities, practice cultural humility, and follow the Culturally and Linguistically Appropriate Services (CLAS) Standards.

Utilization measures:
Achieve a target of the 75th percentile nationally by MY 2027 for BC+ and SSI HMO performance on the following measures:

a) HEDIS Prenatal and Postpartum Care, including both age groups for under 21 and over 21 (PPC2-AD)

b) HEDIS Postpartum Depression Screening and Follow-Up for age 21 and older (PDS-AD)

Additionally, DMS will eliminate population disparities by race and ethnicity in these utilization measures by MY 2027.

[3] Detailed specifications for HEDIS Social Needs Screening measure are updated annually by NCQA. NCQA published an overview as the measure was introduced for 2023. DHS does not intend to require HMOs to use a specific screening tool or intervention, however, encourages HMOs to consider using the screening instruments NCQA lists in the measure specifications.

Outcome measures:

c) DMS will reduce the rate of Live Births Weighing Less Than 2,500 Grams (LBW-CH) from 10.6% (CY 2022) for Wisconsin Medicaid birthing members to be at or below the overall statewide baseline rate of 7.8% for all birthing parents (CY 2022). By 2027 DMS will reduce this rate for the African American or Black, Not Hispanic or Latino population (18.4% baseline) to be at or below the rate for the White, Not Hispanic/Latino populations (8.5% baseline).

d) DMS will reduce the rate of low-risk C-Sections disparities by race/ethnicity by MY 2027.

Objective 3: Increase stratification of performance measures by member demographics with a goal to identify and address health disparities.

a) DMS will comply with CMS' requirements to increase stratification of mandatory Child and Adult Core Set metrics beginning in 2025 across all Medicaid and CHIP populations reported.

b) Managed Care Plans will align with NCQA stratifications of race, ethnicity, and language for an increasing number of HEDIS measures, reported to NCQA and DMS annually.

Objective 4: Care4Kids will prioritize identification, assessment, and coordination of care for their members' health concerns when entering out-of-home care by MY 2027.

a) Increasing timely out-of-home care health screens, completed within two days of enrollment, to identify any immediate medical, urgent mental health, or dental needs.

b) Increasing timely comprehensive initial assessment, completed within thirty days of enrollment, of a child's health to identify acute or chronic physical health conditions; oral health concerns; and developmental or behavioral health-related needs.

c) Ongoing monitoring and updating treatment plans via a comprehensive care plan with input from members, families, providers, and other key individuals.

Goal 3: Support overall quality improvement through compliance with federal requirements, contracts, and Wisconsin benchmarks.

By identifying key areas to monitor, DMS can ensure the integrity of the programs we oversee as well as continually improve performance. Our goal is to create a structure that has both ongoing fixed elements for continuous program improvement and areas of flexibility to change and pivot based on new and changing state and federal requirements as well as industry priorities.

Objective 1: Managed care plans in all programs will have at least 90% compliance in network adequacy standards beginning in MY 2025.

DMS currently has provider network adequacy standards for time, distance, and provider to member ratio standards. All managed care plans must demonstrate compliance with standards at regular checkpoints in a calendar year. Plans found with inadequacies in their networks are subject to corrective action. Managed care plans must remediate all identified access inadequacies within six months.

Objective 2: Managed care plans will continue to screen each new member to identify specific health and health related social needs (i.e.,

member needs screening).

Over the next three years, a primary focus will be on the measurement and validation of managed care member screening, including monitoring the frequency of completed member screening, evidence of compliance with standards found in chart reviews, and enhanced direction for care management requirements.

a) BC+ HMOs will meet or exceed minimum standards of 35%, and SSI HMOs will meet or exceed minimum standards of 50% by MY 2027.

b) In Care4Kids, children will have a timely (completed within two days of enrollment) out-of-home health screen to identify any immediate medical, urgent mental health, or dental needs 62% of the time by MY 2027.

Objective 3: By MY 2027, BC+ and Medicaid SSI HMOs and Care4Kids will have a compliance score of at least 80% or higher for the Annual Compliance Tool (ACT).

DMS utilizes the ACT to monitor program and contract requirements, review current performance, and gather data to set future performance standards. Managed care plans, including Care4Kids, will be held to a standard review each year to ensure consistent quality of policies. DMS will identify and improve standards of quality for members by ensuring regular oversight and clear benchmarks.

Objective 4: The Family Care and Partnership MCOs will have an overall care management review (CMR) score of 90% or higher for both Family Care and Partnership programs by MY 2027.

The CMR is completed by the external quality review organization (EQRO). A CMR is an optional activity identified in CMS External Quality Review (EQR) Protocols, Protocol 9: Conducting Focus Studies of Health Care Quality. A CMR determines an MCO's level of compliance with the DMS-MCO contract. The information gathered during a CMR helps assess the access, timeliness, quality, and appropriateness of care an MCO provides to its members. CMR activities and findings are part of DHS' overall strategy for providing quality assurances to the Centers for Medicare & Medicaid Services regarding the 1915(c) Home and Community Based Services Waivers which allow the State of Wisconsin to operate its Family Care programs.

Objective 5: By MY 2027, Family Care and Partnership MCOs will have an overall quality compliance review (QCR) score of 98% or higher.

QCRs are a mandatory review activity identified in 42 C.F.R § 438.358 and conducted by the EQRO according to federal protocol standards. The review assesses the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care and LTSS.

Standards are reviewed in a two-year cycle for each MCO. The first year of the cycle includes the MCO Standards, followed by Quality Assessment and Performance Improvement (QAPI) and Grievance Standards in the second year. The baseline overall compliance score will be provided following the second year of the cycle (fiscal year 2023-2024, report due fall 2024).

Objective 6: Maintain or improve provider participation in Wisconsin Medicaid for key provider types.

For some provider types, especially impacted by COVID-19, provider participation in the health care and long-term care industry has declined or is at risk of decline, as such DMS wants to maintain access for the Medicaid managed care program members. For other provider types being affected by the aging population and challenges in rural areas of the state, DMS wants to increase member access to providers.

Quality Metrics and Performance Targets

Wisconsin works collaboratively with managed care plans and partners to identify opportunities for continuous quality improvement. Through our quality assurance activities and quality improvement initiatives, Wisconsin will monitor the following performance measures to evaluate the effectiveness of the health care delivered by managed care plans. These performance measures demonstrate if we are successful on each of the goals and objectives.

Targets are intended to drive continuous quality improvement on the program level. Wisconsin may have additional measures used for measuring individual managed care plan compliance and performance, as communicated in managed care contracts, quality guides, or other technical materials.

National Core Indicators® (NCI®) initiative provides a suite of surveys to collect data regarding the lives of people with disabilities, their families, older adults, and staff. There are two separate surveys: 1) NCI-Aging and Disabilities (AD) and 2) NCI-Intellectual and Developmental Disabilities (IDD) In-Person Survey (IPS) Surveys.

For HEDIS measures listed in the table, Wisconsin compares HMO and Care4Kids performance against the national Quality Compass performance data released by the National Committee for Quality Assurance (NCQA). NCQA uses national measure results grouped into tiers for benchmarking purposes. In the table below, our statewide performance (typically a percentage) is shown and compared to one of NCQA's benchmark ranges:

- below the 50th percentile nationally
- between the 50th and 67th percentile nationally
- between the 67th and 75th percentile nationally
- above the 75th percentile nationally

Figure 1: Example of HEDIS measure results compared to national benchmarks

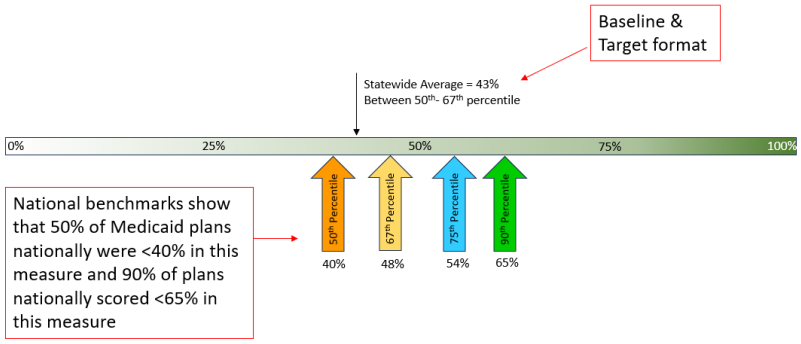

Table 4: Goals, Objectives, and Performance Measures

For dates listed in the table below, we will achieve the performance measure target by the end of each measurement year. For example, "By MY 2027" means the target will be reached upon completion of MY 2027, in which the performance measures results will be calculated and reported in 2028. This allows each managed care program to conduct their quality improvement activities through the full measurement year.

Measures listed below from national measure stewards may be updated if the measure steward retires or replaces a measure.

Goals, Objectives, and Performance Measures			
Goal 1: Improve member health and social connectedness as measured by aggregate performance on specified priority measures.			
Objective 1: Increase the number of Medicaid HEDIS measures in the Adult and Child Core Sets that meet or exceed the NCQA National Medicaid HEDIS median (50th percentile in Quality Compass) by MY 2027.			
Quality measure	**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
Percentage of BC+ and SSI HMOs who have achieved 50th National percentile on 50% of the measures in a designated measure list comprised of HEDIS measures on CMS's Adult and Child Core Sets. See Table 5 below for list of measures. *(State-Developed)*	(MY2022) BC+ HMOs= 28.6% SSI HMOs = 77.8%	(2025) – 100% of HMOs with 50% of measures achieving the 50th percentile. (2026) – 100% of HMOs with 65% of measures achieving the 50th percentile. (2027) – 100% of HMOs with 80% of measures achieving the 50th percentile.	BC+ and SSI

Objective 2: Improve health outcomes for Wisconsin Medicaid members living with chronic conditions by establishing a target of the 75th percentile nationally for HEDIS measures for chronic health conditions and increase the percentage of SSI members who receive transition care following a hospitalization by MY 2027.				
	Quality measure	**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
2a.	**Asthma Medication Ratio (AMR) - ages 5-18** *(HEDIS Measure)* The percentage of members 5–18 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	**BC+ (2022)** Age 5-11 = 73.9% Below 50th Percentile Age 12–18 = 69.6% 50th – 67th Percentile **C4K (2025)** Baseline available with MY2025	(2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+, SSI, and C4K
2a.	**Asthma Medication Ratio (AMR) - ages 19-64** *(HEDIS Measure)* The percentage of members 19–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	**BC+ (2022)** Age 19–50 = 60.5% Between 50th – 67th Percentile Age 51–64 = 67.5% Between 67th – 75th Percentile **SSI (2022)** Age 19–50 = 63.1% 50th – 67th Percentile Age 51–64 = 64.8% Between 50th – 67th Percentile	(2025) – 67th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI
2b.	**Controlling High Blood Pressure (CBP)** *(HEDIS Measure)* The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	**BC+ (2022)** 65.5% 67th – 75th Percentile **SSI (2022)** 67.4% Above 75th Percentile	(2025) – 75th Percentile (2026) – 75th Percentile (2027) – 75th Percentile	BC+ and SSI

2b.	**Glycemic Status Assessment for Patients with Diabetes (GSD)** *(HEDIS Measure)* The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: Glycemic Status <8.0%. **Measure formerly named Hemoglobin A1c Control for Patients with Diabetes (HBD)*	**BC+ (2022)** Glycemic Status <8.0% = 54.4% Between 50th – 67th Percentile **SSI (2022)** Glycemic Status <8.0% = 56.1% Between 67th – 75th Percentile	(2025) – 67th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI
2b.	**Plan All-Cause Readmissions (PCR)** *(HEDIS Measure)* For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. (A lower rate indicates better performance)	**BC+ (2022)** Ages 18–64 (O/E) ratio = .918 Between 67th – 75th Percentile **SSI (2022)** Ages 18–64 (O/E) ratio = .946 Between 50th – 67th Percentile	(2025) – 67th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI
2b.	Increase the percentage of SSI members who receive transition care withing 5 days following a hospitalization. *(State-Developed Measure)*	(2023) 35.1%	(2025) – 36% (2026) – 37% (2027) – 38%	SSI

Objective 3: Improve population health through the increased provision of preventative care and primary care for all members by MY 2027.				
Quality Measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
3a., 3c.	**Child and Adolescent Well-Care Visits (WCV)** *(HEDIS Measure)* The percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	**BC+ (2022)** Total Ages = 45.9% Below 50th Percentile **SSI (2022)** Ages 18–21 = 23.0% Below 50th Percentile **C4K (2025)** Baseline available with MY2025	(2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+, SSI, and C4K
3a., 3c.	**Well-Child Visits in the First 30 Months of Life (W30)** *(HEDIS Measure)* The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. 2. Well-Child Visits for Age 15 Months–30 Months.	**BC+ (2022)** First 15 months = 56.8% Below 50th Percentile 15–30 Months = 62.8% Below 50th Percentile **C4K (2025)** Baseline available with MY2025	(2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+, SSI, and C4K
3a., 3c.	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)** *(HEDIS Measure)* The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. • BMI percentile • Counseling for Nutrition • Counseling for Physical Activity	**BC+ (2022)** BMI percentile (All Ages) = 77.7% Below 50th Percentile Counseling for Nutrition (All Ages) = 65.4% Below 50th Percentile Counseling for Physical Activity (All Ages) = 59.9% Below 50th Percentile	(2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI

3a., 3c.	**Lead Screening in Children (LSC)** *(HEDIS Measure)* The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	**BC+ (2022)** 65.9% Between 50th – 67th Percentile **C4K (2022)** 86.9% 95th Percentile	**BC+ and SSI HMO** (2025) – 67th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **C4K** (2025) – 90th Percentile (2026) – 90th Percentile (2027) – 95th Percentile	BC+, SSI HMO, and C4K
3a., 3c.	**Childhood Immunization Status (CIS)** *(HEDIS Measure)* The percentage of children 2 years of age in the measurement year who had a vaccination by their second birthday. The measure calculates a rate for each vaccine and separate combination rates.	**BC+ (2022)** Combination 3 = 61.0% Below 50th Percentile **C4K (2022)** Combination 3 = 79.1% 95th percentile	**BC+ and SSI HMO** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **C4K** (2025) –95th Percentile (2026) – 95th Percentile (2027) - 95th Percentile	BC+, SSI, and C4K
3a., 3c.	**Immunizations for Adolescents (IMA)** *(HEDIS Measure)* The percentage of adolescents 13 years of age who had vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and separate combination rates.	**BC+ (2022)** Combination 2 = 36.3% Between 50th – 67th Percentile **C4K (2022)** Combination 2 = 76.3% 95th percentile	**BC+ and SSI HMO** (2025) – 67th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **C4K** (2025) – 95th Percentile (2026) – 95th Percentile (2027) – 95th Percentile	BC+, SSI, and C4K

3a, 3c.	**Chlamydia Screening (CHL)** *(HEDIS Measure)* The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	**BC+ (2022)** Total Ages 16-24 =50.5% Below 50th Percentile **SSI HMO (2022)** Total Ages 16-24 = 62.9% Between 50th – 67th Percentile **C4K (2025)** Baseline available with MY2025	(2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+, SSI, and C4K
3a., 3c.	**Topical Fluoride for Children (TFC)** *(HEDIS Measure, adapted from DQA/ADA)* The percentage of members 1–4 years of age who received at least two fluoride varnish applications during the measurement year.	**BC+** Baseline available with MY2025 for HMOs providing dental services. **C4K** Baseline available with MY2025 for HMOs providing dental services.	(2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and C4K
3a., 3c.	**Oral Evaluation, Dental Services (OED)** *(HEDIS Measure, adapted from DQA/ADA)* The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year	**BC+ and SSI** Baseline available with MY2025 for HMOs providing dental services. **C4K** Baseline available with MY2025.	(2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+, SSI, and C4K
3a.	**Colorectal Cancer Screening (COL)** *(HEDIS Measure)* The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.	**BC+ (2022)** Total Ages = 35.5% *National Comparison Data Not Available for 2022* **SSI (2022)** Total Ages = 43.8% *National Comparison Data Not Available for 2022*	(2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI

3a.	**Cervical Cancer Screening (CCS)** *(HEDIS Measure)* The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer.	**BC+ (2022)** 66.6% Below 50th Percentile **SSI (2022)** 58.7% Below 50th Percentile	(2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI
3a.	**Breast Cancer Screening (BCS-E)** *(HEDIS Measure)* The percentage of members 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.	**BC+ and SSI HMO** Baseline available MY 2023	(2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI
3a.	**Adult Immunization Status (AIS-E)** *(HEDIS Measure)* The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.	**BC+ and SSI HMO** Baseline available MY 2025	(2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI
3b.	**Influenza (Flu) Vaccination** *(State-Developed Measure)* Percentage of members during the measurement period who receive an influenza immunization.	(2023) 63.8%	Increase by 3% (1% each year) (2025) – 65% (2026) – 66% (2027) – 67%	FC and FCP
3b.	**Pneumococcal Vaccination** *(State-Developed Measure)* Percentage of members during the measurement period who receive a pneumococcal immunization.	(2023) 89.2%	Increase by 3% (1% each year) (2025) – 90% (2026) – 91% (2027) – 92%	FC and FCP

Objective 4: Increase overall health, safety, and social connectedness of members receiving long-term supports and services by MY 2027.				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
4a.	Increase care coordination by increasing timely follow-up/monitoring to verify authorized services and supports were received by members. *(State Developed Measure, LTSS Measure)*	(2023) 57% FC 51.1% FCP	(2025) – 60% (2026) – 65% (2027) – 70%	FC and FCP
4a.	The percentage of people who report that they know who to talk to if they want to change services. *(NCI-AD and NCI-IDD Surveys, LTSS Measure)*	Baseline 2021-2022 NCI-IDD FC/FCP = 93% NCI-AD FC = 90% FCP = 85%	Increase by 3% (1% each year) NCI-IDD (2025) – 94% (2026) – 95% (2027) – 96% NCI-AD (2025) FC= 91% FCP = 86% (2026) FC= 92% FCP = 87% (2027) FC= 93% FCP = 88%	FC and FCP
4b.	Members will report increased rates of positive levels of satisfaction with the number of opportunities to participate in social activities (survey response, on a 5-point scale). *(State Developed Measure, LTSS Measure)*	(2023) FC = 3.6 FCP = 3.5	(2025) – 4.0 out of 5.0 (2026) – 4.0 out of 5.0 (2027) – 4.0 out of 5.0	FC and FCP

4b.	The percentage of people who do the things they like in their communities as much as they want. *(NCI-AD and NCI-IDD Surveys, LTSS Measure)*	Baseline 2021-2022 NCI-IDD FC/FCP = 59% NCI-AD FC = 63% FCP = 58%	Increase by 3% (1% each year) NCI-IDD (2025) – 60% (2026) – 61% (2027) – 62% NCI-AD (2025) FC= 64% FCP = 59% (2026) FC= 65% FCP = 60% (2027) FC= 66% FCP = 61%	FC and FCP
4c.	Each Family Care and Partnership MCO will increase the percentage of members aged 18–66 who are working in Competitive Integrated Employment settings by 3% annually over their previous year performance. *(State Developed Measure, LTSS Measure)*	Baseline = Q4 2024 results	(2025) – 3%-point increase (2026) – 3%-point increase (2027) – 3%-point increase (Targets indicate % point increases over previous MY performance by MCO)	FC and FCP
4d.	Increase number of individuals statewide who have completed the Certified Direct Care Professional (CDCP) program. *(State-Developed Measure, LTSS Measure)*	(June 2024) Baseline = 541 individuals	(December 2025) – 5,500 (December 2026) – 7,500 (December 2027) – 10,000	FC and FCP
4d.	Achieve 1,500 MCO providers or agencies statewide participating in the Certified Direct Care Professional (CDCP) program by 2027. *(State-Developed Measure, LTSS Measure)*	(June 2024) Baseline = 1,066 providers/agencies	(December 2025) – 1,300 (December 2026) – 1,400 (December 2027) – 1,500	FC and FCP

4d.	The percentage of people who report staff treat them with respect. *(NCI-AD and NCI-IDD Surveys, LTSS Measure)*	Baseline 2021-2022 NCI-IDD FC/FCP = 93% NCI-AD FC = 90% FCP = 85%	Increase by 3% (1% each year) NCI-IDD (2025) – 94% (2026) – 95% (2027) – 96% NCI-AD (2025) FC= 91% FCP = 86% (2026) FC= 92% FCP = 87% (2027) FC= 93% FCP = 87%	FC and FCP
Objective 5: Increase utilization of outpatient, least-restrictive behavioral health and substance use disorder services by MY 2027.				
	Quality measure	**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
5a.	**Follow-Up Care for Children Prescribed ADHD Medication (ADD)** *(HEDIS Measure)* The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. 1. Initiation Phase 2. Continuation and Maintenance	**BC+ (2022)** Continuation/Maintenance = 40.1% Below 50th Percentile **C4K (2025)** Baseline available with MY2025	**BC+ HMO** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **C4K** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and C4K

5a.	**Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)** *(HEDIS Measure)* The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	**BC+ (2022)** Total Ages = 59.7% Below 50th Percentile **C4K (2025)** Baseline available with MY 2025	**BC+ HMO** (2025) –50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **C4K** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and C4K
5a.	**Initiation and Engagement of Substance Use Disorder Treatment (IET)** *(HEDIS Measure)* The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement, ages 13–64. Two rates are reported: 1. Initiation of SUD Treatment. 2. Engagement of SUD Treatment	**BC+ (2022)** Engagement of SUD treatment (Total) All Ages = 16.2% Between 50th – 67th Percentile **SSI (2022)** Engagement of SUD treatment (Total) All Ages = 10.9% Below 50th Percentile	**BC+ HMO** (2025) – 67th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **SSI** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI
5a.	**Follow-Up After Hospitalization for Mental Illness (FUH)** *(HEDIS Measure)* The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.	**BC+ (2022)** 30-Day Follow-up, Total Ages = 63.5% Between 67th – 75th Percentile **SSI (2022)** 30-Day Follow-up, Total Ages = 62.6% Between 50th – 67th Percentile **C4K (2022)** 30-Day Follow-up = 63.4% Below 50th Percentile	**BC+ HMO** (2025) – 60th Percentile (2026) – 70th Percentile (2027) – 75th Percentile **SSI HMO** (2025) – 60th Percentile (2026) – 70th Percentile (2027) – 75th Percentile **C4K** (2025) – 60th Percentile (2026) – 70th Percentile (2027) – 75th Percentile	BC+, SSI, and C4K

5a.	**Follow-Up After Emergency Department Visit for Mental Illness (FUM)** *(HEDIS Measure)* The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.	**BC+ (2022)** 30-Day Follow-up, Total Ages = 49.1% Below 50th Percentile **SSI (2022)** 30-Day Follow-up, Total Ages = 57.7% Between 50th – 67th Percentile **C4K (2023)** Baseline available with MY 2023	**BC+ HMO** (2025) – 60th Percentile (2026) – 70th Percentile (2027) – 75th Percentile **SSI HMO** (2025) – 60th Percentile (2026) – 70th Percentile (2027) – 75th Percentile **C4K** (2025) – 60th Percentile (2026) – 70th Percentile (2027) – 75th Percentile	BC+, SSI, and C4K
5a.	**Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)** *(HEDIS Measure)* The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: 1. Blood glucose testing 2. Cholesterol testing 3. Blood glucose and cholesterol testing.	**BC+ (2022)** Blood glucose testing (Total) = 53.9% Below 50th Percentile **C4K (2025)** Blood glucose testing Baseline available with MY 2025	**BC+ HMO** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **C4K** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and C4K
		BC+ (2022) Cholesterol testing (Total) = 27.5% Below 50th Percentile **C4K (2025)** Cholesterol testing (Total) Baseline available with MY 2025	**BC+ HMO** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **C4K** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and C4K
		BC+ (2022) Blood glucose and cholesterol testing (Total) = 25.8%	**BC+ HMO** (2025) – 50th Percentile	BC+ and C4K

		Below 50th Percentile **C4K (2025)** Blood glucose and cholesterol testing (Total) Baseline available with MY 2025	(2026) – 67th Percentile (2027) – 75th Percentile **C4K** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	
5a.	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)** *(HEDIS Measure)* The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	(2022) BC+ = 58.3% Below 50th Percentile SSI = 71.2% Above 75th Percentile	**BC+ HMO** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **SSI HMO** (2025) – 75th Percentile (2026) – 75th Percentile (2027) – 75th Percentile	BC+ and SSI
5a.	**Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)** *(HEDIS Measure)* The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	(2022) BC+ = 77.1% Below 50th Percentile SSI = 77.4% Below 50th Percentile	**BC+ HMO** (2025) – 60th Percentile (2026) – 70th Percentile (2027) – 75th Percentile **SSI HMO** (2025) – 60th Percentile (2026) – 70th Percentile (2027) – 75th Percentile	BC+ and SSI
5a.	**Follow-Up After Emergency Department Visit for Substance Use (FUA)** *(HEDIS Measure)* The percentage of emergency department (ED) visits among members ages 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for	BC+ (2022) 30-Day Follow-up, Total Ages = 40.7% Between 67th – 75th Percentile SSI (2022) 30-Day Follow-up, Total Ages = 44.2%	**BC+ HMO** (2025) – 75th Percentile (2026) – 75th Percentile (2027) – 75th Percentile **C4K** (2025) – 75th Percentile	BC+ and SSI

	which there was follow-up.	Above 75th Percentile	(2026) – 75th Percentile (2027) – 75th Percentile	
5b.	Reduce the number of restrictive measures applications for individuals with behavioral health needs in Family Care and Partnership by 3% over the next 3 years (or 1% per year over the next 3 years). *(State-Developed Measure, LTSS Measure)*	(2023) 162 restrictive measure applications	(2025) – 160 (2026) – 158 (2027) – 156 (Reduce by 3% by 2027 or 1% per year over the next 3 years.)	FC and FCP
5c.	Reduce the number of Family Care members who are admitted to IMDs multiple times in a calendar year by 7% over the next 3 years. *(State-Developed Measure, LTSS Measure)*	(2023) 25.5% of FC members admitted to an IMD were readmitted at least once in the same year.	(2025) – 23.5% (2026) – 21% (2027) - 18.5%	FC

Goal 2: Reduce health disparities and support underserved populations providing person-centered services and supports.

Objective 1: By MY 2027, address members' Health-Related Social Needs (HRSNs) identified through screening by ensuring they receive a corresponding intervention. Every managed care member is screened at least once annually for HRSNs, and each managed care program has established policies and procedures for addressing identified HRSN needs.

	Quality measure	Statewide performance baseline (year)	Statewide performance target (year)	Program(s)
1a.	**Social Need Screening and Intervention (SNS)** *(HEDIS Measure)* The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive. Six rates are reported: 1) Food screening; 2) Food intervention; 3) Housing screening; 4) Housing intervention;	Baseline data available MY 2025	**BC+ HMO** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **SSI HMO** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile (targets apply to each of the	BC+ and SSI

	5) Transportation screening; 6) Transportation intervention		six screenings)	
1a.	Increase the percentage of Family Care and Family Care Partnership members who respond positively to the question of how well their supports and services meet their needs. *(State-Developed Measure, LTSS)*	(2022) FC= 82% FCP = 78%	Increase of 1% each year	FC and FCP
1b.	Increase the percentage of member-centered service plans that are comprehensive by properly addressing members' assessed needs and personal goals. *(State-Developed Measure, LTSS Measure)*	(2023) Combined FC and FCP = 75.5% based on CMS 372 Report.	(2025) – 80% (2026) – 85% (2027) – 90% (Target measures are combined FC and FCP)	FC and FCP
1c.	Increase the percentage of unique member needs and services addressed through timely follow-up by 8% over the 2023 baseline of 84% as measured through the annual Care Management Review conducted by the EQRO. *(State-Developed Measure)*	(2023) 84%	(2025) – 86% (2026) – 89% (2027) – 92%	C4K
Objective 2: Improve healthy birth outcomes by increasing utilization of certain maternity services, by reducing rates of babies with low birth weights, and by reducing rates of C-section utilization, while also reducing racial and ethnic disparities in these measures, by MY 2027.				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
2a.	**Prenatal and Postpartum Care (PPC2)** *(HEDIS Measure)* The percentage of deliveries in which women had a prenatal care visit in the first trimester or had a postpartum visit on or between 7 and 84 days after delivery.	**BC+ and SSI** Baseline data available MY 2024	**BC+ HMO** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **SSI HMO** (2025) – 50th Percentile	BC+ and SSI

			(2026) – 67th Percentile (2027) – 75th Percentile	
2b.	**Postpartum Depression Screening and Follow-up** **(PDS-E)** *(HEDIS Measure)* The percentage of deliveries in which members were screened for clinical depression during the postpartum period and received follow-up care within 30 days if screening was positive.	Baseline available in MY 2025.	**BC+ HMO** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **SSI HMO** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI
2b.	**Prenatal Depression Screening and Follow-Up (PND-E)** *(HEDIS Measure)* The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care.	Baseline available in MY 2025.	**BC+ HMO** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **SSI HMO** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI
2c.	**Live Births Weighing Less than 2,500 Grams (LBW-CH)** *(Centers for Disease Control and Prevention//National Center for Health Statistics Measure)* Percentage of live births weighing less than 2,500 grams. (A lower rate indicates better performance)	(2022) White, Not Hispanic/Latino = 8.5% African American/Black, Not Hispanic/Latino = 18.4%	(2025) – Reduce the disparity by 33% from baseline between White/Not Hispanic and African American/Black group. (2026) – Reduce the disparity by 67% from baseline between White/Not Hispanic and African American/Black group. (2027) – Rates between race/ethnic groups are equal	BC+ and SSI

2d.	**Low-Risk Cesarean Delivery (LRCD-CH))** Percentage of nulliparous (first birth), term (37 or more completed weeks based on the obstetric estimate), singleton (one fetus), in a cephalic presentation (head-first) births delivered by cesarean during the measurement year. (A lower rate indicates better performance.) *(Centers for Disease Control and Prevention//National Center for Health Statistics Measure)*	(2022) White, Not Hispanic/Latino = 21.8% Asian, Not Hispanic/Latino = 28.3% African American/Black, Not Hispanic/Latino = 24% Hispanic or Latino = 23%	(2025) – Reduce the disparity by 33% from baseline between White/Not Hispanic and target groups (2026) – Reduce the disparity by 67% from baseline between White/Not Hispanic and target groups (2027) – Rates between race/ethnic groups are equal	BC+ and SSI

Objective 3: Increase stratification of performance measures by member demographics with a goal to identify and address health disparities by MY 2027.

	Quality measure	Statewide performance baseline (year)	Statewide performance target (year)	Program(s)
3a.	Increase number of federally reported Child and Adult Core Set measures for Wisconsin's Medicaid and CHIP populations that are stratified by member demographics (race, ethnicity, sex, and geography), beginning in 2025 through 2028, per CMS' implementation timeline. *(State-Developed Measure)*	(2024) 0% of mandatory measures	(2025) – 25% of mandatory measures (as defined by CMS) (2026/2027) – 50% of mandatory measures (as defined by CMS) (2028) – 100% of mandatory measures (as defined by CMS)	BC+, SSI, C4K, FC, and FCP
3b.	Percentage of Managed Care Plans that stratify required HEDIS measures in accordance with HEDIS specifications for race and ethnicity. *(State-Developed Measure)*	MY 2024 Baseline of 22 HEDIS Measures	(2027) – 100% of Managed Care Plans	BC+, SSI, and C4K

Objective 4: Care4Kids will prioritize identification, assessment, and coordination of care for their members' health concerns when entering out-of-home care by MY 2024.				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
4a., 4b.	**Timely Comprehensive Initial Health Assessment** *(State-Developed Measure)* The percent of children newly enrolled in Care4Kids during the reporting period who have a Comprehensive Initial Health Assessment completed within 30 days of their enrollment date.	(2022) 69.9%	(2025) – 74% (2026) – 79% (2027) – 85%	C4K
4c.	**Care Plan Input** *(State-Developed Measure)* The number of member records reviewed with a care plan developed with input from all required persons including the child's parent and/ or legal guardian.	(2023) 24%	(2025) – 29% (2026) – 34% (2027) – 39%	C4K
Goal 3: Support overall quality improvement through compliance with federal requirements, contracts, and Wisconsin benchmarks.				
Objective 1: Managed care plans in all programs will have at least 90% compliance in network adequacy standards beginning in MY 2025.				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
1a.	Percentage of managed care plans that are at or above 90% compliance with provider network drive time and distance standards and provider to member ratio requirements for each county in their service area. *(State-Developed Measure)*	(2023) BC+ = 84.6% SSI =88.9% C4K = 100% FC = 100% FCP = 100% *Represents percentage of managed care plans that meet or exceed the 90% compliance standard	(2025) – 90% (2026) – 95% (2027) – 100% (targets apply to all program areas and managed care entities)	BC+, SSI, C4K, FC, and FCP

Objective 2: Managed care plans will continue to screen each new members to identify specific health and health related social needs (i.e., member needs screening).				
	Quality measure	**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
2a.	Increase percentage of HMOs achieving minimum standards of 35% for BC+ and 50% for SSI for screening new members within contracted timelines and expectations. *(State-Developed Measure)*	(2023) BC+ = 8% SSI = 60% *Represents percentage of HMOs that meet or exceed the minimum screening standards.	(2025) – 33% of HMOs (2026) – 67% of HMOs (2027) – 100% of HMOs	BC+ and SSI
2b.	**Timely Out-of-Home Care Health Screen** *(State-Developed Measure)* The percent of children who had a timely out-of-home health screen to identify any immediate medical, urgent mental health, or dental needs.	(2022) 53.1%	(2025) - 56% (2026) - 59% (2027) - 62%	C4K
Objective 3: By MY 2027, BadgerCare Plus and Medicaid SSI HMOs and Care4Kids will have a completion score of 80% or higher for the Annual Compliance Tool (ACT).				
	Quality measure	**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
3a.	Increase percentage of HMOs achieving a completion score of at least 80% for the ACT. *(State-Developed Measure)*	BC+, SSI, and C4K Baseline will be established following the 2024 review cycle.	(2025) – 33% of plans (2026) – 67% of plans (2027) – 100% of plans	BC+, SSI, and C4K
Objective 4: The Family Care and Partnership MCOs will have an overall care management review (CMR) score of 90% or higher for both Family Care and Partnership programs by MY 2027**.**				
	Quality measure	**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
4a.	Percent of care management review (CMR) standards met for all indicators in Protocol 9: Conducting Focus Studies of Health Care Quality *(State-Developed Measure)*	**FY2023-2024** Family Care (FC) =84.8% Family Care Partnership (FCP) = 80.2%	(2025) – 86% (2026) – 88% (2027) – 90%	FC and FCP

Objective 5: By MY 2027, Family Care and Partnership MCOs will have an overall quality compliance review (QCR) score of 98% or higher.				
	Quality measure	**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
5a., 5b.	**QCR compliance review score** *(State-Developed Measure)* QCR assesses the strengths and weaknesses of the MCO related to quality, timeliness, and access to services, including health care and LTSS.	Baseline will be established following the FY2023-2024 review cycle.	(2025) – 95% (2026) – 96% (2027) – 98%	FC and FCP
Objective 6: Maintain or improve provider participation in Wisconsin Medicaid for key provider types.				
	Quality measure	**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
6a.	Maintain or increase the percentage of private emergency ambulance service providers participating in the Medicaid program compared to all private emergency ambulance service providers operating in the State of Wisconsin. *(State-Developed Measure)*	(FY2023) 87%	Increase of 1% each year (2025) – 88% (2026) – 89% (2027) – 90%	BC+ and SSI
6a.	Increase the number of HCBS providers (e.g., home health, occupational therapists, personal care, etc.). participating in Wisconsin's adult long-term care waiver programs.	*Baseline will be developed in January 2026, after Wisconsin's new provider enrollment system for adult long term care providers is fully operational		FC and FCP
6a.	Maintain or improve the percentage of Wisconsin hospitals (excluding psychiatric and veteran hospitals) that participate in Wisconsin Medicaid. a. Non-Critical Access hospitals b. Critical Access hospitals	(2024) a. 100% b. 98%	100%	BC+ and SSI

Table 5: Measure Names and Stratification (from Goal 1, Objective 1 applicable to HMOs)

Measure Name and Stratification	Applies to BadgerCare Plus HMOs	Applies to SSI HMOs
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB); Total	X	X
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E); Continuation and Maintenance Phase	X	
Asthma Medication Ratio (AMR); Total	X	X
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) - Blood Glucose and Cholesterol Testing - Total - Blood Glucose Testing - Total - Cholesterol Testing - Total	X	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP); Total	X	
Breast Cancer Screening (BCS-E)	X	X
Controlling High Blood Pressure (CBP)	X	X
Cervical Cancer Screening (CCS)	X	X
Chlamydia Screening (CHL); Total	X	X
Childhood Immunization Status (CIS); Combination 3	X	
Colorectal Cancer Screening (COL); Total	X	X
Follow-Up After Emergency Department Visit for Substance Use (FUA); 30 days, Total	X	X
Follow-Up After Hospitalization for Mental Illness (FUH); 30 days, Total	X	X
Follow-Up After Emergency Department Visit for Mental Illness (FUM); 30 days, Total	X	X
Glycemic Status Assessment for Patients with Diabetes (GSD); Glycemic Status <8.0%. *(formerly Hemoglobin A1c Control for Patients with Diabetes (HBD) and Comprehensive Diabetes Care (CDC))*	X	X
Initiation and Engagement of Substance Use Disorder Treatment (IET); Engagement of SUD Treatment - Total ages, Total drugs	X	X
Immunizations for Adolescents (IMA); Combination 2	X	
Lead Screening in Children (LSC)	X	
Plan All-Cause Readmissions (PCR); -Ages 18-64, Observed/Expected	X	X
Prenatal and Postpartum Care (PPC) - Postpartum Care - Timeliness of Prenatal Care	X	X
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	X	X
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	X	X
Well-Child Visits in the First 30 Months of Life (W30)	X	

Measure Name and Stratification	Applies to BadgerCare Plus HMOs	Applies to SSI HMOs
-First 15 Months -15 Months-30 Months		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI percentile, Total - Counseling for Nutrition, Total - Counseling for Physical Activity, Total	X	
Child and Adolescent Well-Care Visits -Total (WCV)	X	

Public Posting of Quality Measures and Performance Outcomes

As part of the Quality Strategy, DMS references many performance measures. This section provides a list of publicly available websites with more detail on the performance measures and on the quality assurance or quality improvement results, organized by program. Additional performance measures and outcomes data may be published in the future, as new data becomes available.

BadgerCare Plus (BC+) and Medicaid SSI HMO

- External Quality Review Organization Annual Technical Report: Quality for BC+ and Medicaid SSI (wi.gov) - Includes Performance Improvement Project validation, Compliance with Standards, Performance Measure Validation, Obstetric Medical Home record reviews, SSI care management record reviews, and Information Systems Capabilities Assessments
- HMO Report Card (star ratings) - This information is also published in the HMO Program Guides for each program and in the HMO Selection Tool within ACCESS.
- HMO accreditation status:
  - BC+: HMO Information
  - Elderly, Blind, or Medicaid and SSI Medicaid HMO Information

Family Care and Partnership HMO

- External Quality Review Organization Annual Technical Report: Family Care, Family Care Partnership, and PACE: External Quality Review Activities - Includes Performance Improvement Project validation, Compliance with Standards, Performance Measure Validation, care management record reviews, and Information Systems Capabilities Assessments
- National Core Indicators:
  - National Core Indicators Project: Adult Surveys Overview
  - Results are available:
    - WI reports for National Core Indicators – In Person Survey (NCI-IPS) surveys for individuals with Intellectual and Developmental Disabilities
    - National Core Indicators – Aging and Disability (NCI-AD) report for Wisconsin
- Wisconsin Satisfaction Survey: Family Care: Program Monitoring and Evaluation

- Family Care and Partnership Scorecards: This includes MCO staff turnover rates, star ratings for how satisfied other members are with the MCO, and star ratings for how well the MCO follows state quality standards.
  - 2024 Scorecard Guide for MCOs, P-02484-24 (PDF)
  - 2024 Family Care MCO Scorecard, P-02553-24 (PDF)
  - 2024 Family Care Partnership MCO Scorecard, P-02554-24 (PDF)
- Pay-for-Performance Information is under the drop down "Quality Reports."

Care4Kids

- External Quality Review Organization Annual Technical Report - Includes Performance Improvement Project validation, Compliance with Standards, Performance Measure Validation, Care4Kids care management record reviews, and Information Systems Capabilities Assessments.
- Care4Kids' parent health plan, Chorus Community Health Plan, is NCQA accredited.

Performance Improvement Projects and Interventions

Each managed care plan conducts two performance improvement projects (PIPs) annually, one clinical topic and one non-clinical topic, in alignment with CMS External Quality Review Protocol 1[4]. DMS approves plans' proposed PIPs prior to implementation to ensure they are designed to achieve significant improvement in health outcomes and member satisfaction that is sustainable over time. Topics should be selected based on a needs assessment that demonstrates the topic is relevant to the needs of the plan's population. Plans are encouraged to collaborate with members, providers, and other partners to assist with topic selection. Plans submit annual reports on the status and results of their approved PIPs, which DMS' EQRO validates against the CMS External Quality Review Protocol for PIPs. The EQRO provides plans with a report summarizing their PIPs' strengths and recommendations that can be used when designing future PIPs. Plans can propose two-year projects for one or both PIPs. Plans that propose two-year projects submit proposals for approval and annual reports for EQRO validation for each of the two years. DMS has the authority to select a particular topic for the PIPs. Additionally, CMS may specify performance measures and topics for PIPs in consultation with DMS and interested parties. DMS maintains discretion to dictate a specific PIP topic or require additional performance improvement projects per year. Each plan type has supplementary PIP requirements that are outlined in their contracts and supplemental guides and summarized below.

BC+ and SSI HMO

Each of the HMO's PIPs must address a disparity identified in the target population based on rural/urban residence, race, ethnicity, sex, gender, age, primary language, disability, etc. HMOs are encouraged to partner with providers and community-based organizations in their PIP interventions and consider how the interventions are culturally and linguistically appropriate to address the identified disparity. While HMOs have flexibility in their choice of PIP topics, they are encouraged to select topics in areas where they are underperforming. For example, HMOs that do not meet their pay for performance or other performance measure goals are encouraged to select those areas as PIP topics. DMS provides a list of suggested PIP topics in the annual HMO Quality Guide. HMOs may propose alternative performance improvement topics during the PIP proposal approval process, but topic selection is subject to DMS approval.

[4] February 2023; https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf

Table 6: Suggested HMO PIP Topics

Clinical	Non-Clinical
Adolescent immunizations	Access and availability of services
Antidepressant medication management	Care coordination
Asthma management	Implementation of Culturally and Linguistically Appropriate Services (CLAS) Standards
Behavioral health and substance abuse screenings and management	Member satisfaction and experience of care
Blood lead testing	Social determinants of health
Breast cancer screening	SSI Care Management
Childhood immunizations	Trauma-informed care
Childhood obesity interventions	
Dental care	
Diabetes management	
Emergency department utilization	
Health outcome improvements in chronic conditions, preventative care, primary care, behavioral health, etc. through care team extensions (for example, community health workers, doulas, health coaches, etc.)	
Hypertension management	
Prenatal and postpartum depression screening and follow-up	
Preventable hospital readmissions	
Tobacco cessation	
Well-child visits	

BC+ and SSI HMO Performance Improvement Projects (PIPs) for MY 2021-2024 can be found in the Appendix of this document.

Family Care and Partnership MCOs

Family Care and Partnership MCOs must incorporate health equity considerations into at least one PIP. At a minimum, member demographic data stratifications should be included that are relevant to the proposed PIP topic. The MCO PIP Guide, updated and issued every two years to align with the MCO contract, includes the following examples of broad PIP topic options MCOs can consider:

- Quality of care (for example, chronic conditions, palliative or hospice care, advance care planning)
- Chronic care self-management (for example, diabetes, heart disease, including hypertension)
- Behavioral health conditions (for example, anxiety disorders, depression)
- Trauma-informed care (for example, quality improvement of education processes and care capacity on multiple levels – MCO staff, members, providers, provider staff; effects of the pandemic)

- Access to preventive health (for example, adult vaccinations, mammograms, colonoscopies, regular primary care visits and follow-up, use of technology for health care access)
- Access to behavioral health resources (for example, utilization of existing behavioral health resources; use of technology resources)
- Access to mental health screening and/or self-care resources, mobilization of mental health first aid, access to/use of technology resources
- Access to community participation (for example, access to community-based recreation, exercise, volunteer opportunities, social groups, access to/use of technology resources)
- Access to or satisfaction with caregiver supports (for example, respite care, behavioral/mental health supports, member satisfaction)
- Quality of provider and provider staff supports (for example, COVID recovery, mental health, provider services to members)

Family Care and Partnership MCO Performance Improvement Projects (PIPs) for MY 2021-2024 can be found in the Appendix of this document.

Care4Kids

Annually, Care4Kids is contractually required to conduct one clinical PIP and one non-clinical PIP, one of which must have a focus on reducing health disparities. The performance improvement project must be applicable to member quality improvement needs that are assessed by the PIHP.

Table 7: Care4Kids Performance Improvement Projects (PIPs) for MY 2021-2024

PIP Topic	PIP Aim	PIP Interventions
Timely Completion of Initial Comprehensive Health Exam (ICHE) Letter	Increase the percentage of newly enrolled children who received an ICHE and had an ICHE letter shared with the primary care provider prior to the appointment from 53% to 80%.	• Increase monitoring of dates for ICHEs and letters. • Review medical records of new enrollees to ensure the ICHE letter is sent before exam. • Adjust the staffing model to a single health care coordinator to mitigate miscommunication. • Conduct chart reviews to verify the ICHE occurred and the ICHE letter had been sent.
Increased COVID-19 Vaccination Rate for Adolescents	Increase the percentage of children above the age of 12 years who are fully vaccinated with an authorized COVID-19 vaccine from 23% to 27%.	• Use electronic medical record to prompt conversations during outreach and enable outcome tracking. • Partner with child welfare and biological parents/legal guardians to obtain consent and share resources. This includes communication with youth when age appropriate to provide information and resources. • Continue to collaborate with community partners to increase movable vaccine clinics in targeted zip codes of underserved communities.

PIP Topic	PIP Aim	PIP Interventions

Decrease Access to Care Barriers for Not Timely Initial Comprehensive Health Exam Completion and Increased Care Coordination Efforts	Decrease the percentage of Initial Comprehensive Health Exam (ICHE) barriers related to access from 46% to 35% for all newly enrolled children in Care4Kids.	• Identify and implement best practice for ICHE tracking and addressing barriers to timeliness:
		  ○ Earlier appointment offered but caregiver or child welfare professional could not bring youth.
		  ○ Provider unavailable for an earlier appointment.
		• Change how information is communicated when providers move practices.

Increase Mental Health Assessments After a Mental Health In-patient Hospitalization	Increase the percentage of Care4Kids members who have an outpatient visit with a mental health provider within 30 days of a mental health in-patient hospitalization.	Care4Kids internal behavioral health therapist communicates with the in-patient team when a member is admitted to and discharged from a mental health facility to ensure that the member receives the appropriate outpatient service once back in the community.
Increase Legal Guardian Information Sharing and Communication to Increase Birth to 3 Referral Completion	With outreach from a healthcare coordinator, utilizing DMS-developed materials about the Birth to 3 Program, to the parents/legal guardians, within 30 days of a positive developmental screen, increase successful referrals to the Birth to 3 Program for children in Care4Kids who are under 3. A successful referral from Care4Kids to the Birth to 3 program is achieved when a biological parent/legal guardian says yes to the Birth to 3 program evaluation.	Healthcare coordinator outreach to parents/legal guardians utilizing DMS-developed materials about the Birth to 3 Program. Outreach is defined as direct contact, phone conversation, virtual meeting, or face-to-face meeting.
Decreasing Rate of Emergency Room Visits for Children Classified as "High Utilizers"	Conduct case staffing with the Care4Kids team (healthcare coordinator, supervisor, and lead) on a child who has two ER visits or more (to preempt the child meeting a threshold for criteria of a "high utilizer" of four or more visits to the ER) result in a decreased rate of emergency room visits from 2.5% in MY2022 to or below 1.75% in MY2024, for all members enrolled in Care4Kids.	• Conduct case staffing to review member's care plan and collaborative discussion regarding any member needs and identifying additional resources. • Each member will receive appropriate care coordination following the case staffing to address any barriers and provide education on available resources. • Individualize response according to member needs including considerations for education needs, medical conditions, cultural, religious, and/or any language barriers.

Transition of Care Policy

In response to the federal managed care regulations update that began in 2016, and in alignment with 42 C.F.R § 438.62, Wisconsin began implementing transition of care policies for members transitioning between fee for service and managed care, as well as between managed care plans. The transition of care policy is intended to ensure continued access to services during transitions between programs. Wisconsin's transition of care policy for its managed care programs focuses on standards for transitions upon enrollment, while enrolled, and upon disenrollment. The full details of each organization's transitions of care policy can be found within their internal policies and procedures.

BC+ and SSI HMO

- At the time of enrollment:
  - DMS shares available Medicaid claims, encounter, and prior authorization data with a member's HMO to assist with care coordination. All HMOs are required to submit approved prior authorization data to DMS monthly to assist with this process.
  - DMS requires HMOs to ensure continuity of care for members receiving health care and services under fee for service prior to their enrollment in the HMO and for newly enrolled members switching HMO enrollment.
  - HMO ensures members have access to an in-network provider list.
- During enrollment:
  - HMOs must ensure members receive continued access to previous services when the absence of continued services would pose serious health or hospitalization, which includes the following:
    a. Provide continued access to services consistent with previous access levels.
    b. Authorize coverage of Medicaid services with the member's current provider for the first 90 days of enrollment.
    c. Authorize approved prior authorizations at the utilization level previously authorized for 90 days. Exceptions to the 90-day requirement will be allowed in situations where the member agrees to change providers, the member agrees to a lower level of care, or if the HMO can document that continuing the care would result in abuse, safety, or quality concerns.
    d. Have a detailed automated system for collecting all information on member contacts by care coordinators, case managers, and any other staff that has a direct impact on the member's access to services.
  - HMOs must coordinate services to the member between settings of care including appropriate discharge planning for short-term and long-term hospital and institutional stays. HMOs ensure continuity of care including completing medication reconciliation, ensuring members have a comprehensive understanding of their treatment plan, and assisting members with scheduling follow-up appointments with their primary care provider or specialists as needed after a member is discharged from an emergency department, hospital, nursing home, or rehabilitation facility.
  - HMOs must participate in Wisconsin Statewide Health Information Network (WISHIN) to facilitate exchange of medical records between health plans and providers. This includes subscribing to the WISHIN Pulse community health record, submitting a member roster as specified by WISHIN, and subscribing to the WISHIN Patient Activity Report (PAR). SSI HMOs must submit member care plans.
  - HMOs are required to provide any additional care management assistance to members with specific conditions or circumstances as needed or requested. This includes the following:
    a. Members receiving crisis or other intensive behavioral health services when transitioning back to in-network community settings.
    b. Members receiving obstetric medical home care management when transitioning to post-partum and pediatric care.

    c. Between settings transitions for those participating in the HIV/AIDS Health Home.
    d. SSI members (elderly, blind, or disabled adults) after a discharge from a hospital or facility stay.
    e. Coordination with school-based services to assure continuity of care during school breaks.
  - HMOs that identify a member with a special health care need are also required to share that information if the member transitions to another health plan or has other coverage, to avoid duplication of services.
- Disenrollment:
  - HMOs must assist members who want, and are eligible, to disenroll by making appropriate referrals and by assisting in the transfer of medical records to new providers.

Family Care and Partnership MCO

Family Care and Partnership MCOs must ensure that members who transition to the MCO from fee-for-service Medicaid or from one MCO to another MCO have continued access to services.

- At the time of enrollment:
  - The member is asked to sign a release of information to share member information, documents, and records within three business days from the date of signature to the MCO.
  - If the MCO does not receive the information, documents, and records within this timeframe, they should contact DMS.
- During enrollment:
  - The MCO should authorize coverage of services with the member's current providers until a care plan is developed.
  - If the member is receiving a service from a provider not in the new MCO's network, the MCO must permit the member to continue to receive the service from that provider until the MCO can establish a new service or service provider.
- Disenrollment:
  - The MCO must assist members who want to disenroll by helping them contact the Aging and Disability Resource Center or Tribal Aging and Disability Resource Specialist and by assisting in the transfer of medical records to new providers.

Care4Kids

Care4Kids is contractually bound to maintain transitions of care policy for their members including:

- Upon enrollment in Care4Kids:
  - Ensuring continuity of care for members previously receiving care via fee-for-service Medicaid (FFS MA) or an HMO utilizing member-specific information provided by DMS, including claims/encounter history, prior authorizations, and upcoming non-emergency medical transportation trips.
  - Obtaining information from medical providers.
  - Ensuring access to the appropriate providers in the PIHP's network.
- During enrollment:
  - Coordination with school-based services to assure continuity of care during school breaks.
- Disenrollment:

- The PIHP is responsible for facilitating the transfer of medical records to ensure continuity of care when a member switches health plans, providers, moves out of the Care4Kids service area, or is placed in a Residential Care Center
- The PIHP engages in transition planning prior to the child leaving the medical home. Transition plans are developed with input from the child, their family, and the treatment team.
- Transition activities include a final meeting with the treatment team and a successful transfer of medical records to new health plans and providers.
- The PIHP shall assist members who return to the FFS MA system by making appropriate referrals and by assisting in the transfer of medical records to new providers, if necessary.

- Wisconsin Statewide Health Information Network (WISHIN)
  - Care4Kids is required to participate in WISHIN to facilitate the timely exchange of medical records between health plans and providers.

Plan to Eliminate Disparities

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

DMS' Equity and Inclusion vision statement is, "A thriving Wisconsin where our workforce and programs are equitable, inclusive, and antiracist; everyone giving and receiving DMS services realizes their full potential." To achieve this vision, DMS has selected the Institute for Healthcare Improvement (IHI) Improving Health Equity Framework[5] as its foundation for addressing health equity. The 2025–2027 disparities plan adopts the IHI framework and builds on the efforts outlined in the DMS' 2021–2024 Managed Care Quality Strategy disparities plan. This framework is an organizational tool that DMS uses to show alignment within our managed care programs. Utilizing this framework will ground the work DMS' managed care programs (HMOs, MCOs, and Care4Kids) are doing to reduce health disparities and improve health equity, while recognizing that each program is at a different stage in the framework. Using this framework also makes alignment with other efforts within DHS and the state easier to navigate, including DHS' Wisconsin State Health Improvement Plan (SHIP) 2023–2027, the Wisconsin Collaborative for Healthcare Quality (WCHQ), and the Maternal Health Task Force.

All DMS managed care programs will have focus areas that include:

- Data collection and definition work
- Alignment with National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)
- Performance improvement projects (PIPs)
- Member engagement

[5] Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

Current State Overview:

BC+ and SSI HMOs achieved NCQA's Health Plan Accreditation and Health Equity Accreditation or Multicultural Healthcare Distinction as of January 1, 2024. DMS has required HMOs to implement the CLAS standards and performs ongoing oversight of HMO implementation through the Annual Compliance Tool review of policies and procedures from each HMO. HMOs have addressed health disparities in their PIPs since 2020, including completing cultural competency self-assessments and implementing health disparity reduction plans that helped them build infrastructure to support health equity and decrease institutional racism; completing assessments of their efforts to screen for determinants of health and developing and implementing action plans to improve screening efforts for social determinants of health; and partnering with community-based organizations to provide services to address the need identified through a needs assessment. HMOs must have Member Advisory Councils established by January 1, 2025, that will advise the HMOs on their policies and operations, including how well they are meeting the needs of the members and how outcomes can be improved.

Family Care and Partnership MCOs have been required to incorporate health equity in one of their two PIPs since 2022. At a minimum, MCOs consider member demographic data stratification and are encouraged to select and examine at least two stratifications in efforts to identify health equity quality improvement opportunities within their PIP topic. Additionally, MCOs are required to incorporate values of honoring member's beliefs and being respectful to member and staff culture, heritage, and other identity facets into their policies, administration, provider contract, services, and appeals and grievance processes.

Care4Kids: Health disparities for children in out-of-home care have long been documented. They are more likely to have chronic medical conditions than their peers as well as behavioral health concerns. They are also more likely to have been living in poverty prior to their removal from the home. Due to the high vulnerability of the population, DMS is addressing health disparities through a multi-pronged approach.

Table 8: Disparities Plan for 2025–2027

<table>
<tr><th rowspan="2">Managed Care Program</th><th colspan="5">IHI Improving Health Equity Framework</th></tr>
<tr><th>Make Health Equity a Strategic Priority</th><th>Build Infrastructure to Support Health Equity</th><th>Address the Multiple Determinants of Health</th><th>Decrease Institutional Racism</th><th>Partner with the Community to Improve Health Equity</th></tr>
<tr><td rowspan="3">BC+ and SSI HMOs</td><td colspan="5">• Maintain NCQA Health Equity Accreditation.
• Encourage HMOs to explore NCQA Health Equity Accreditation Plus, as additional effort to meet CLAS standards and increase community partnerships.</td></tr>
<tr><td colspan="5">Work toward incorporating all 15 National CLAS Standards into their organizational infrastructure by 2027.</td></tr>
<tr><td></td><td></td><td colspan="3">Design and implement performance improvement projects (PIPs) that address identified disparities in the populations the HMOs serve, building on improvement strategies implemented in previous PIPs.</td></tr>
</table>

					Develop plan for involving members in Quality Improvement (QI) activities and soliciting member feedback in addition to their contractually required Member Advisory Council.
Family Care and Partnership MCOs	Demonstrate commitment to improving health equity at all levels of the MCO. For example, strategic planning efforts designed to reduce disparities, organizational self-assessment and training opportunities for all staff, etc.	• Improve data collection and stratification capabilities to inform future health equity efforts. • Incorporate National CLAS Standards into organizational practices and delivery of services by 2027.	Incorporate equity considerations into the topic selection, improvement strategies, and data analysis of all PIPs by 2027.	Expand requirements to foster equity and inclusion among MCO staff and providers.	Develop plan for involving members in QI activities and soliciting diverse member feedback in addition to their contractually required Member Advisory Committee.
Care4Kids	• Maintain NCQA Health Equity Accreditation. • Explore NCQA Health Equity Accreditation Plus • Maintain National CLAS Standards within organizational infrastructure.	Improve data collection and stratification capabilities to inform future health equity efforts.	C4K will work with State partners to identify opportunities to connect children and their families to HRSN resources, particularly as the families approach reunification.	• Utilize the data from PIPs to identify racial health disparities and work together with DMS to develop action plans. • Review how staff demographic data compares to that of C4K's members.	Develop plan with Department of Children and Family partners for involving members in QI activities and soliciting member feedback.

DMS Activities

As DMS works with its managed care programs on building the infrastructure needed to improve health equity, DMS will continue its efforts to identify, evaluate, and reduce health disparities.

DMS will continue to promote and enhance its innovative free online professional workforce advancement program (WisCaregiver Careers) to increase the number of direct care workers in Wisconsin's home and community-based settings. Wisconsin's direct caregiving workforce is the backbone of home and community-based services. However, today one in four direct caregiver positions is vacant. In response, DMS partnered with the University of Wisconsin-Green Bay to launch an initiative to train 10,000 people as certified direct care professionals (CDCP) by 2027. The self-paced curriculum includes direct care topics such as safety, ethics, and communication. Most candidates will be able to complete the free program in about 30 hours and then must pass an online exam to earn certification.

In addition to caregiving training, the program includes WisCaregiver Connections, a robust platform to support engagement with this workforce. Eligible employers can post job openings and automatically match with job seekers, while CDCPs can explore open positions and find the right fit.

DMS will continue to focus on improving data collection and analysis that improves our ability to make data-driven decisions and take appropriate action across all managed programs by:

- Improving definitions to allow for consistent measurement and reporting including race, ethnicity, primary language, sex, age, disability status, and geography. For Family Care and Partnership, stratification by target group (frail elder, intellectual/developmental disability, physical disability, aging, ID/DD, PD) will be included.
- Defining disparity consistently to make prioritizing areas that need immediate action easier.
- Measuring screening for social determinant needs and resulting interventions using the HEDIS Social Needs Screening and Intervention (SNS) measure. (See Goal 2, Objective 1)
- Improving qualitative data on member experience by engaging members in program design and feedback on quality improvement opportunities.

Each state is required to stratify quality measures reported to CMS for the Adult Core Set, Child Core Set, and Home and Community Based Services Quality Measure Set. Results stratification by population demographics for each of the mandatory measures by CMS' deadlines will take collaboration between DMS, the managed care plans, and other partners such as the EQRO and data analytics vendors, as we work towards those federal implementation dates, including full compliance in 2028.

As noted in Goal 2, Objective 3, disparities in maternal health continues to be an area of focus for DMS. Specific initiatives designed to improve pregnancy and birth outcomes include:

- Using results of the recent Obstetric Medical Home (OBMH) evaluation to improve this initiative's outcomes.
- Expanding partnership opportunities with other programs in the state with mutual goals to leverage resources and build additional capacity for improvement. Opportunities include:
    - Assisting the DHS Division of Public Health (DPH) Maternal Health Innovation Program with its efforts to address maternal mortality and morbidity inequities, including their Maternal Health Task Force and Maternal Mortality Review Team (MMRT).
    - Working with the Wisconsin Collaborative for Healthcare Quality (WCHQ) on ways DMS can partner with their Maternal Health Advisory Group on reducing disparities.

- Participating in CMS' planned affinity groups for its Maternal and Infant Health Initiative.
- Applied for the CMS Transforming Maternal Health program, and with award funding, DMS will accelerate and expand our current plans to eliminate maternal health disparities in our state.
- Partnering with DPH in the implementation of the Wisconsin State Health Improvement Plan (SHIP).

- Continuing to demonstrate the need for Wisconsin to expand postpartum Medicaid eligibility coverage through outcomes data and member input.

Identification of Participants with Special Health Care Needs

Pursuant to 42 C.F.R. § 438.208(c)(1), DMS defines members with special health care needs for BC+ and SSI Medicaid, Family Care and Partnership, and Care4Kids below.

BC+ and SSI HMOs

Members with special health care needs include BC+ members who are in one or more of the following categories:

1. Children with serious emotional disorders
2. Children who have multiple significant chronic health problems that affect multiple organ systems and result in functional limitations
3. Members who are pregnant or who are 0 to 12 months postpartum
4. Members who have been incarcerated in the past 12 months
5. Members with a mental illness and another chronic condition (i.e. cardiovascular disease, diabetes, asthma)
6. Members who are homeless

Members with special health care needs include all SSI managed care members.

HMOs are required to conduct an initial screen of all new members. The screen must ask questions to assist in identification of the member's physical, mental, and behavioral health needs. DMS provides HMOs with current and historical data at the time of a member's enrollment to assist the HMO in identifying those with special health care needs. On an ongoing basis, each HMO regularly conducts utilization review to identify members in need of services or care coordination through member outreach, claims and encounters, prior authorizations, admissions, and other information.

Family Care and Partnership MCOs

Members served in Family Care and Partnership are limited to those who are a frail elder or adults with an intellectual or physical disability who require LTSS to remain in the community. Members have access to all 1915(c) waiver services. Accordingly, DMS has determined that identification of members with special health care needs for additional services is not necessary.

Care4Kids

Members with special health care needs include Care4Kids members who require additional assistance for conditions that may be medical, mental, developmental, physical, or psychological in addition to placement in out-of-home care.

Members are identified through the comprehensive screening and assessments performed by the PIHP. Those determined to have special heath care needs are connected with the appropriate additional services or Medicaid programs, including Children's Long Term Support Waiver, Comprehensive Care Services, and early intervention. Additionally, members are assessed and triaged for enhanced care management. Compliance with these requirements is monitored through the Quality Assurance and Performance Improvement process.

Network Adequacy and Availability of Services

For all managed care programs, DMS will work towards compliance with the federal requirements in 42 C.F.R. § 438.358 to include the External Quality Review Organization (EQRO) in network validation. In the interim, each program has specific network adequacy policies and mechanisms to monitor access, as described below.

BadgerCare Plus and SSI HMO

The BadgerCare Plus and SSI HMO Contract establishes time/distance, ratio, and appointment wait time network adequacy standards according to 42 C.F.R. § 438.68, 206, and 207, among Dental, Primary Care Provider (PCP), Obstetric/Gynecology (OB/GYN), Behavioral Health (including mental health and substance use), Hospital and Urgent Care Centers (Table-1). HMOs provide monthly in-network data files which DMS analyzes for adequacy annually and upon a significant change. The analysis also takes into consideration member grievances and appeals; out-of-network utilization; Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys; and External Quality Review Organization analysis to determine the HMO's network adequately provides access, availability, and capacity to members.

Family Care and Partnership MCO

The DHS-developed provider network adequacy standards require Family Care and Partnership MCOs to establish and maintain a provider network that is adequate to ensure timely delivery of all services in the Family Care, and Partnership benefit packages. DMS and MetaStar complete separate evaluations and audits of each MCO's provider network to determine if adequacy is met or not. The MCO Provider Network Adequacy, P-02542 standards are determined by DMS and encompass member enrollment, utilization of services, member target groups, and health care needs.

Partnership MCO

DMS must verify all 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.

Care4Kids

Care4Kids must demonstrate covered services within the provider network are available and accessible to members per 42 C.F.R. § 438.206, 438.68, and 438.14 and has the capacity to serve expected enrollment in its service area per 42 C.F.R. § 438.207. Care4Kids must establish provider network access, availability, and capacity expectations within provider's contracts, to include standards, protocols, methods of monitoring, reporting, and remediation. DHS conducts an annual network adequacy analysis confirming the network for Care4Kids adequately supports members' access availability.

Clinical Practice Guidelines

Wisconsin Managed Care Clinical Practice guidelines will be updated and clarified over the next two years. During that time, Wisconsin DMS will engage with partners, providers, and managed care plans to further define appropriate use of clinical practice guidelines. At a minimum, HMOs and MCOs are required to provide at least the same benefits as those provided under Wisconsin Fee for Service Medicaid (FFS). Some FFS clinical practice guidelines include:

- The Advisory Committee on Immunization Practices (ACIP)
- U.S. Preventative Services Task Force published recommendations
- Bright Futures prevention and health promotion for infants, children, adolescents, and their families

HMOs and MCOs are required to use valid, reliable, evidence-based clinical practice guidelines to assist practitioners in approaching healthcare issues in a systematic, appropriate manner per 42 C.F.R. 438.236. HMO and MCO guidelines are available to their provider networks via the HMO/MCO Provider Manual and DHS and/or respective HMO/MCO websites. The links to HMO and MCO clinical practice guidelines are included in Table 9.

BadgerCare Plus and SSI HMO

BadgerCare Plus and SSI HMOs must identify at-risk populations for preventive services and develop strategies for reaching members included in this population. Public health resources can be used to enhance HMO health promotion and preventive care programs. HMOs must have mechanisms for facilitating appropriate use of preventive services and educating members on health promotion. At a minimum, an effective health promotion and prevention program includes HMO outreach to and education of its members, tracking preventive services, practice guidelines for preventive services, yearly measurement of performance in the delivery of such services, and communication of this information to providers and members. DMS encourages HMOs to develop and implement disease management programs and systems to enhance the quality of care for individuals identified as having chronic or special health care needs known to be responsive to the application of clinical practice guidelines and other techniques. HMOs agree to implement systems to independently identify members with special health care needs and to utilize data generated by the systems or data that may be provided by the DMS to facilitate outreach, assessment, and care for individuals with special health care needs.

Family Care and Partnership MCO

Clinical Practice Guidelines are guidelines that are developed in consultation with network providers to assist them in applying the current evidence in making decisions about the care of individual members. MCOs must review and update practice guidelines periodically, as appropriate. MCOs must use practice guidelines for prevention and wellness services that include member education, motivation, and counseling about long-term care and health-care-related services. MCOs also must disseminate or make available the guidelines to providers for whom the guidelines apply and to members, upon request. Clinical Practice Guidelines that are condition-specific and/or disease-related must include the following elements:

- An overview of the condition/disease, information related to anticipating, recognizing, and responding to condition/disease-related symptoms
- Information related to best practice standards for prevention and management of condition/disease
- guidelines/process for an interdisciplinary team to use regarding negotiating incorporation of condition/disease prevention and management plan with members
- A quality assurance monitoring of guideline effectiveness

Table 9: Clinical Practice Guideline Links by HMO/MCO

HMO	Link to Clinical Practice Guidelines
Anthem	https://providers.anthem.com/docs/gpp/WI_CAID_ClinicalPracticeGuidelinesMatrix.pdf
Chorus Community Health Plan (CCHP)	https://chorushealthplans.org/for-providers/clinical-and-preventative
Dean	https://deancare.com/providers/clinical-guidelines
GHC of Eau Claire (GHS-EC)	https://group-health.com/providers/quality-care-and-patient-safety
GHC of South Central Wisconsin (GHS-SCW)	https://ghcscw.com/members/badgercare-plus/
iCare	https://www.icarehealthplan.org/Education/Resources.htm
MercyCare	https://www.mercycarehealthplans.com/providers/behavioral-health-guidelines/ Password: MERCYDOCTORS https://www.mercycarehealthplans.com/providers/clinical-practice-guidelines/ Password: MERCYDOCTORS
MHS Health Wisconsin (MHS)	https://www.mhswi.com/providers/quality-improvement/practice-guidelines.html
Molina	https://www.molinahealthcare.com/molinaclinicalpolicy
Network Health Plan (NHP)	https://www.mhswi.com/providers/quality-improvement/practice-guidelines.html
Quartz	https://quartzbenefits.com/providers/provider-resources/provider-resources-clinical-guidelines/
Security Health Plan (SHP)	https://www.securityhealth.org/providers/tools-and-resources/clinical-practice-guidelines

HMO	Link to Clinical Practice Guidelines
UnitedHealthcare (UHC)	https://www.uhcprovider.com/en/policies-protocols/clinical-guidelines.html

Family Care and Partnership MCO	Link to Clinical Practice Guidelines
Community Care	*https://www.communitycareinc.org/providers/current-providers/practice-guidelines* *Also located under "Members," redirecting to the same link.*
iCare	https://www.icarehealthplan.org/Education/Resources.htm
Lakeland Care	Forms and Materials | Lakeland Care Provider Network (lakelandcareinc.com)
Molina, aka My Choice WI	https://mychoicewi.org/providers/resource-library/?wpv-resource-type=guideline&wpv_aux_current_post_id=281&wpv_aux_parent_post_id=281&wpv_view_count=318

Care4Kids

The Care4Kids contract describes the requirement to develop or adopt practice guidelines in accordance with 42 C.F.R. 438.236(b) and meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of providers in the particular field
- Consider the needs of the PIHP members
- Are adopted in consultation with network providers
- Are reviewed and updated periodically as appropriate

The PIHP must disseminate the practice guidelines to providers and, upon request, to members and potential members. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply must be consistent with the guidelines.

Performance Monitoring and Intermediate Sanctions

DHS has established intermediate sanctions that, at a minimum, meet the sanctions requirements in Part 438 subpart I. The sanctions may include contract terminations, civil monetary penalties, temporary management, termination of enrollment, suspension of enrollment, and suspension of payment.

BadgerCare Plus and SSI HMO

DHS has established the following sanctions for HMOs that fail to meet key performance objectives. These sanctions serve to further the consistency and transparency of the consequences for continued poor performance.

DMS maintains the right to impose sanctions and financial penalties outside of the standards found here or to adjust penalties based on distinct situations or updated benchmarks. The chart below outlines three levels of performance tiers (minor, moderate, and major) with a corresponding

description of enforcement actions. DMS maintains the right to impose sanctions without following the prescribed scheme at any time, including financial penalties, as provided under the BC+ and Medicaid SSI HMO Contract. Financial penalties can be imposed separately or in addition to the outlined sanctions below at the discretion of DMS.

DMS is prioritizing set sanctions for issues pertaining to: Provider Network Adequacy, Member Screening, HEDIS Scores, and the Annual Compliance Tool (ACT). However, DHS may choose to update priorities or benchmarks as determined appropriate.

Table 10: HMO Intermediate Sanctions

	Provider Network	Member Screening	HEDIS	ACT
Examples of Minor Problems	One or more identified inadequacies in HMO's service area	Below established benchmarks	One year with fewer than 50% of HEDIS Measures above the National HEDIS Mean (NHM). Measures defined in Goal 1, Objective 1.	Final score under 80%
Enforcement	• Conditional certification • Formal impact reporting • Geoaccess report	• Request for information • Remediation	• Request for information • Remediation	• Request for information • Remediation
Examples of Moderate Problems	More than two identified inadequacies in HMO's service area and inadequate ratio and/or HMO provider network data issues	Below established benchmarks for more than 1 year	• One year with fewer than 80% of HEDIS Measures above NHM • Three consecutive years or three years within a five-year period with fewer than 50% of HEDIS Measures above the NHM	HMOs with a score between 58-79%
Enforcement	Any of the above, and: • Corrective action plan • Allow members in problem service area(s) to voluntarily disenroll from HMO	Any of the above, and: • Corrective action plan	Any of the above, and: • Corrective action plan • Suspend auto assignment	Any of the above, and: • Corrective action plan • Suspend auto assignment

	Provider Network	Member Screening	HEDIS	ACT
Examples of Major Problems	Provider network inadequacies or inadequate ratios that continue over six months, and/or access issues for members	Below established benchmarks for more than two years	• Three consecutive years or three within the last five years with fewer than 80% of HEDIS Measures above NHM • Four consecutive years or four years within the last five years with fewer than 50% of HEDIS Measures above the NHM	HMOs with a score below 57%
Enforcement	• Any of the above and: • Suspend auto assignments in problem service area(s) • Suspend all future enrollment in problem service area(s), and move current members into another HMO of the member's choice • Decertification in affected service areas	• Any of the above, and: • Suspend all new enrollment (voluntary and auto assignment) • Corrective action with public notification	• Any of the above, and: • Suspend all new enrollment (voluntary and auto assignment) • Contract termination	• Any of the above, and: • Suspend all new enrollment (voluntary and auto assignment) • Corrective action with public notification • Contract termination

During the period of 2021-2024, DMS implemented the below corrective actions and remediation activities for HMOs. Note that no financial sanctions have been applied during this timeframe.

Provider Network Adequacy: Corrective Action (Conditional certification and monitoring), Decertification, Enrollment Suspension, Data CAP

- Number of HMOs/Year/Corrective Action
  - 2 /2024/ Decertification/enrollment suspension in 8 counties
  - 2 /2024/Enrollment Suspension in 11 counties
  - 10 /2024/Conditional certification in 21 counties
  - 2 /2023/Conditional certification in 8 counties
  - 1 /2022/Conditional certification in 3 counties
  - 1 /2021/Formal CAP for Network Adequacy Provider and Facility File Data Submission

ACT: Corrective Action (Remediation)

- Number of HMOs/Year/Corrective Action/Topic
  - 12 /2024/ Remediation to improve member screening

Family Care and Partnership MCO

DHS has established sanctions for Family Care and Family Care Partnership MCOs that fail to meet performance standards or have violated or breached the contract. DMS has the authority to impose a variety of different sanctions, including:

- Applying civil monetary penalties
- Appointing temporary management for an MCO
- Notifying members of their right to disenroll
- Suspending new enrollments
- Imposing a plan of correction and/or intensive oversight of MCO operations
- Withholding, recovering, or suspending payments
- Terminating the contract with an MCO

The MCO contract outlines intermediate sanctions for failure to comply with the contract. Some examples for receiving a sanction outlined in the contract includes, but is not limited to:

- Failure to provide services
- Failure to meet quality standards and performance criteria
- Failure to ensure the health and safety of members
- Misrepresentation or false statements to members, potential members, subcontractors, providers, DHS or CMS
- Discrimination among members on the basis of health status or need for health services
- Failure to provide timely payments or denies payment for services
- Marketing violations

When DMS becomes aware of any potential failures of an MCO to meet any of its performance expectations under federal or state law or the contract, DHS initiates an investigation to determine if any failures have occurred. If DHS determines that a sanction is warranted, it will

determine which sanction(s) will be imposed and then informs the MCO and CMS (within 30 days) via written notices describing the nature and bases of the sanction and any due process protections that DHS elects to provide the MCO.

DHS monitors the plan of correction through ongoing meetings with the MCO. The sanctions remain in effect until DHS determines that the MCO has implemented the appropriate corrective actions as outlined in the plan of correction. DHS provides notice to both the MCO and CMS (within 30 days) when the sanction is lifted.

Specifics regarding sanctions can be found in the MCO contract: Sanctions for Violation, Breach, or Non-Performance.
For years 2022, 2023, and 2024, DHS has imposed 2 sanctions.

1) Sanction date: March 2023
   - Type: Imposition of plan of correction requiring the MCO to use a DHS-approved evaluation consultant as a matter of intensive oversight.
   - Reason: Failure to meet the quality standards and performance criteria of the DHS/MCO contract such that members are not at substantial risk of harm.

2) Sanction date: December 2023
   - Type: Imposition of plan of correction requiring the MCO to use a DHS-approved evaluation consultant as a matter of intensive oversight.
   - Reason: Failure to meet the quality standards and performance criteria of the DHS/MCO contract such that members are not at substantial risk of harm.
   - Type: Civil monetary penalties to be determined by DHS.
   - Reason: Failure to meet the quality standards and performance criteria of the DHS/MCO contract such that members are not at substantial risk of harm.

External Quality Review Arrangements

DHS contracts with MetaStar, Inc. (MetaStar) to serve as the external quality review organization (EQRO) for managed care programs in the state of Wisconsin. MetaStar's contract is effective 7/1/2023-6/30/2026. Under the contract, MetaStar conducts mandatory and optional evaluations of the managed care programs in alignment with the Centers for Medicare and Medicaid External Quality Review Protocols. The annual technical reports detailing the results of these evaluations are available at:

- Family Care, Family Care Partnership, and PACE: External Quality Review Activities
- BC+, Medical Homes, Prepaid Inpatient Health Plans, and Medicaid Supplemental Security Income Managed Care

Below is a listing of the review activities conducted by MetaStar identifying both optional and mandatory activities.

Table 11: Review activities conducted by MetaStar

Review Activity	Acronym	Mandatory	Optional
Appeal and Grievance Review	A&G		✓
Care Management Review (Record Review)	CMR		✓
Compliance with Standard Review	COMP	✓	
Information System Capability Assessment	ISCA	✓	
Network Adequacy Validation	NAV	✓	
Performance Improvement Project Validation	PIP	✓	
Performance Measure Validation	PMV	✓	

After the EQRO completes the annual technical reports with program strengths and identifies recommendations for improvement, DHS shares results with the managed care plans, posts the reports publicly, and determines if any program changes or remediation are needed as a result of these findings.

42 C.F.R. § 438.360 and § 457.1250(a) allows a state to use information from a Medicare or private accreditation review of a plan in place of the EQRO conducting the activities to avoid duplication. All BC+ and SSI HMOs must be accredited by the NCQA for the Medicaid lines of business. Results of the accreditation and HEDIS audits are utilized to avoid duplication in several reviews.

MetaStar completed a crosswalk comparing the Code of Federal Regulations to the NCQA health plan accreditation requirements identifying gaps not evaluated through accreditation. MetaStar reviews documents from the organizations to evaluate compliance with the identified gaps. The crosswalk is located in the Appendix. Below are the reviews conducted by program.

Table 12: EQR reviews conducted by program

Program	A&G	CMR	COMP	ISCA	NAV	PIP	PMV
BadgerCare+			✓✓	✓✓	✓	✓	✓✓
Family Care	✓	✓	✓	✓	✓	✓	✓
Family Care Partnership	✓	✓	✓	✓	✓	✓	✓
Foster Care Medical Home (Care4Kids)		✓	✓✓	✓✓	✓	✓	✓✓
HIV/AIDS Health Home		✓					
Obstetric Medical Home		✓					
PACE	✓	✓	✓	✓	✓	✓	✓
SSI Managed Care		✓	✓✓	✓✓	✓	✓	✓✓

✓ MetaStar – conducts a full review
✓✓ – MetaStar utilizes results from NCQA to meet requirements

Appendix

Glossary

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

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

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

BadgerCare Plus (BC+): 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.

Benchmark: A 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.

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.

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 comprehensive care plan includes the following components: assessment, diagnosis, expected outcomes, interventions, rationale, and evaluation.

Consumer Assessment of Healthcare Providers and Systems®: A series of patient surveys created by The Agency for Healthcare Research and Quality (AHRQ) rating health care experiences, 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 fifteen 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. For more information, see Culturally and Linguistically Appropriate Services - Think Cultural Health (hhs.gov).

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

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

- BadgerCare Plus and Medicaid SSI HMOs: the current contract defines "disability status" as whether the individual qualified for Medicaid on the basis of a disability.
- Long-term Care PIHPs: The LTC contracts define developmental and physical disabilities as follows:
  - **Developmental Disability:** a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome. This also includes an intellectual disability diagnosed before age 18 and characterized by below-average general intellectual function and a lack of skills necessary for daily living, or another neurological condition closely related to such intellectual disability or requiring treatment similar to that required for such intellectual disability, that has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. "Developmental disability" does not include senility that is primarily caused by the process of aging or the infirmities of aging.
  - **Physical Disability:** a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person. In the context of physical disability, "major life activity" means self-care, performance of manual tasks

unrelated to gainful employment, walking, receptive and expressive language, breathing, working, participating in educational programs, mobility other than walking and capacity for independent living.
    - **Frail Elder:** an individual who is 65 years of age or older and has a physical disability or irreversible dementia that restricts the individual's ability to perform normal daily tasks or that threatens the capacity of the individual to live independently.
- Children's PIHP: For Care4Kids, it means whether the individual qualified for Medicaid on the basis of a disability.

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

External quality review organization (EQRO): 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 (FC): 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 (FCP): 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. Individuals enrolled in Medicaid programs may receive some of their services on a fee-for-service basis outside their managed care program.

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

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

provide:

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

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

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

Health maintenance organization (HMO): An HMO is a type of managed care plan where an insurer offers comprehensive health care services delivered by providers. These providers may be both employees and partners of the HMO, or they may have entered into a referral or contractual agreement with the HMO for the purpose of providing contract-related services for enrolled members. HMOs provide managed care to BadgerCare Plus and SSI members.

Health plans: A health plan is an entity that assumes the risk of paying for medical treatments (i.e., payer, HMO).

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

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

Institution for mental disease: A hospital, nursing facility, or other institution of more than sixteen 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 or long-term 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 or long-term 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 contracted entities can include Health Maintenance Organizations (HMOs), Managed Care Organizations (MCOs), and Prepaid Inpatient Health Plans (PIHPs).

Measurement Year: the twelve-month timeframe during which a service was provided. Generally, this refers to a calendar year (CY) such as January 1 through December 31 as in HEDIS measures, but may refer to a fiscal year (FY) such as July 1 through June 30.

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.

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

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

Network adequacy: The requirement to have enough providers within a geographic area to ensure access to care for individuals needing services.

Pay-for-performance (P4P): Pay-for-performance is a term that describes payment systems that offer financial rewards to plans or providers who achieve, improve, or exceed their performance on specified quality 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 improvement project: A performance improvement project establishes a planned, systematic, organization-wide approach to process design and performance measurement. It also includes measuring the impact of the interventions or activities with the goal of achieving improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, and grievance and appeals processes. These projects are required by the state and topics can be chosen by the managed care plan or prescribed by the state.

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.

Program(s): In this document, programs refer to the health and long-term care programs serving particular Wisconsin Medicaid members through managed care, including BadgerCare Plus, Medicaid SSI, Care4Kids, Family Care, and Family Care Partnership.

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

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

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

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

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.

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).

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

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

HMO Performance Improvement Projects

2024 Health Maintenance Organization (HMO) Performance Improvement Project (PIP) Topics, Aims, and Interventions

This table is posted to comply with 42 CFR 438.340(b)(3)(ii), which requires States to provide a description of the PIPs being implemented annually in accordance with its quality assessment and performance improvement program.
Interested parties can contact the HMOs for more information about these projects. Contact information can be found under the Resources and Help tab on the HMO Providers page at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/ManagedCare/HMOProviders.aspx.

HMO	PIP Topic	PIP Aim	PIP Interventions
Anthem Blue Cross and Blue Shield	Increase the Number of African American and Hispanic Members	Improve Healthcare Effectiveness Data and Information Set (HEDIS®) Diabetes Control <8% for Milwaukee County African American/Black	Implement community health worker (CHW) model to:

HMO	PIP Topic	PIP Aim	PIP Interventions
	with Diabetes with A1C Control < 8% in Milwaukee County	BadgerCare Plus members from 42.4% in measurement year (MY) 2022 to 50.12% and Hispanic BadgerCare Plus members from 41.6% in MY2022 to 50.12% by from January 1, 2024, to December 31, 2024.	• Screen for social determinants of health (SDoH) needs, • Connect members to resources to address identified needs, • Reduce barriers to accessing care, and • Follow-up with members regularly.
	Increase the number of social needs met Anthem BadgerCare Plus and Supplemental Security Income (SSI) Hispanic population at the Kenosha Community Health Center	Between January 1, 2024, to December 31, 2024, Anthem will deploy a Community Health Worker (CHW) to screen all BadgerCare Plus and SSI Hispanic members at Kenosha Community Health Center and increase the screening rates from MY2022 9% to MY2024 21%. Between January 1, 2024, to December 31, 2024, the CHW will close at least 50% of the gaps in social needs in MY2024 based on the BadgerCare Plus and SSI Hispanic members at Kenosha Community Health Center from MY2022 0% to MY2024 13.5%.	Implement CHW model to: • Assess members' social needs and care gaps, • Work with members to develop an action plan, • Connect members to community-based organizations (CBO) and local agencies to access resources, • Follow-up with members regularly, and • Refer members to the Anthem Care Management team for clinical needs.
Chorus Community Health Plans (CCHP)	Strategies to increase Rates of Routine Childhood and Adolescent Immunizations	Increase HEDIS Childhood Immunization Status (CIS) Combo 3 from the target zip codes baseline MY2022 rate of 44.19% to 49.88% for MY2024. Increase HEDIS Immunizations for Adolescents (IMA) Combo 2 from the target zip codes baseline MY2022 rate of 27.23% to 29.44% for MY2024.	• Develop additional culturally competent and linguistically appropriate outreach campaigns to intervene earlier with members who have begun to fall behind on routine immunizations. • Provide regular reports to network medical providers with information about CCHP members who have routine immunization care gaps. • Partner with network medical providers serving "high risk" zip codes to identify opportunities to improve availability and accessibility of routine immunizations and other preventive care services. Support provider partners with culturally competent and trauma-informed materials and education to better support members. • Provide additional training and support to all CCHP staff related to culturally competent and linguistically relevant strategies for supporting members with routine immunization and other preventive care needs.

HMO	PIP Topic	PIP Aim	PIP Interventions
	Identifying and Implementing Strategies to Improve Engagement for Members with Diabetes	Decrease the percentage of non-engaged members with diabetes in the target zip code (53205, 53206, 53208, 53209, 53216, and 53218) population by 3% (from 33.3% in 2023 to 30.3% in 2024). Decrease the percentage of non-engaged Black or African American members with diabetes overall by 2% (from 46.7% in 2023 to 44.7% in 2024).	• Member participation in improvement team. • High touch nurse case management outreach including SDoH screening and support. • Emergency department and Inpatient utilization monitoring and follow-up outreach. • Collaboration with providers and community partners.
Dean Health Plan	Health Disparities Prenatal Care	Improve overall prenatal care rate from 90.40% in MY 2022 to 92% in MY 2024 for Wisconsin BadgerCare Plus members.	• Expansion of doula services focused on self-referrals early in pregnancy as well as perinatal education. • Address most significant SDoH barrier, transportation, through expansion of non-emergency medical transportation coverage. • Expand Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey to include additional questions regarding a member's care being culturally competent. • Conduct regular meetings between the doulas, the health plan, and our clinic partners to for continuous monitoring of the program by reviewing referral and enrollment numbers, addressing any questions or concerns, reviewing options for expansion of services, and discussing program structure.
	Medicaid Health Needs Assessment Health Disparities	Improve overall Medicaid Health Needs Assessment rates from 5.83% in 2022 to 35% in 2024.	• Utilize a multi-channel communications campaign to capture health-related and social determinants of health data from members. • Provide additional information to members who complete the survey about additional services and benefits available.
Group Health Cooperative of Eau Claire (GHC-EC)	Improving Rates of 30-day Follow-Up after Hospitalization (FUH) for Mental Health	Improve HEDIS FUH-30 follow up rates for all BadgerCare Plus members identified as being discharged from a mental health or intentional self-harm hospital stay between January 1 and December 31 of 2024 from 62.5% (MY2022) to achieve a rate at or above the MY2023 Department of Health Services goal (NCQA 75th percentile) rate of 65.38%.	• Improve data collection to identify members timely to ensure they have enough time to follow up with a mental health provider within 30 days of discharge. • Partner with Vantage Point Clinic to offer members an option for in person or telehealth assessments to complete their follow up timely.

HMO	PIP Topic	PIP Aim	PIP Interventions
			• Improve continuity of care between hospitals and outpatient care providers by notifying the member's outpatient mental health provider of their recent hospital stay and discharge, with the understanding that members might be most receptive to a contact from their established provider following discharge. • Explore ways to learn more about the barriers members might experience related to access to mental health care including health literacy levels, transportation, and language barriers.
	Improving Member Satisfaction of Complex Case Management	Increase the completion rate of complex case management program satisfaction surveys for a sample population from 36.8% to 50% for the SSI Medicaid population and from 11.8% to 30% for non-English speaking members from January 1, 2024, to December 31, 2024.	• Explore alternative methods of survey distribution, such as digitally or through email or mail, to help increase completion rate and allow members to answer more honestly than if completing the survey on the phone in person. • Explore ways to send out translated letters for ease of survey completion and high completion rates from members that do not have the means to easily translate the survey. GHC-EC will look into collaborating with CBOs and getting feedback on translation of surveys and other resources. • Improve the program satisfaction survey by analyzing the survey and exploring the potential for alternative or more specific questions. The team will also consider asking members' input into what they would see as valuable to them for case management to consider collaborating with them on.

Group Health Cooperative of South Central Wisconsin (GHC-SCW)	Colorectal Cancer Screening (COL) 46–49 for Non-White Members	Between January 1, 2024, and December 31, 2024, GHC-SCW will eliminate the HEDIS COL disparity rate (noted to be 8.61% in 2022) between white and non-white BadgerCare Plus members 46-49 years old by direct mailing of Cologuard kits to eligible staff model members.	• Use an opt-out approach to engage members to engage members in care.
			  ○ Perform outreach via mail to eligible members, giving them one month to opt out of Cologuard testing.
			  ○ Members that did not opt are sent Cologuard testing kits to encourage colorectal cancer screening.
			• Telephonic follow up with members who do not complete testing within three months.

HMO	PIP Topic	PIP Aim	PIP Interventions
	MyChart "Active Status" Disparity Reduction	GHC-SCW will reduce the MyChart "activated status" disparity rate between African American and Caucasian adult BadgerCare Plus members with a GHC staff model primary care provider by 10% or more between January 2024 and December 2024 by using postal mailings, thereby reducing the disparity rate from 17.4% to 7.4% or lower.	Promote MyChart activation via postal mail to ensure information is accurate, informative, consistent, and presented in a culturally and linguistically appropriate way.
Independent Care Health Plan (iCare)	Controlling Hemoglobin (Hb) A1c Values in the Black, Under-served SSI Membership	SSI Diabetic Workgroup staff will increase the number of members in SSI Black population who meet A1c compliance from MY2022 18.6% to a rate of 35% in MY2024.	• Development of a Diabetic Workgroup to provide education to members within the SSI Black population who have not completed a HbA1c lab or that have an uncontrolled HbA1c lab value. • The Diabetic Workgroup will also discuss potential barriers and address SDoH, such as transportation difficulties, financial and housing barriers, and unemployment; understanding the barriers to diabetic compliance will provide new opportunities and resources for our members.
	Access and Coordination for Alcohol and Other Drug Abuse (AODA) Services in Medicaid Pregnant Members	Increase member engagement for currently pregnant African American SSI members who reside in Milwaukee County with an AODA claim code in the past two years within the Wisconsin Community Services Hub & Spoke Health Home Maternal Program from 0% on 02/01/2024 to 50% by 12/31/2024 (timeframe 03/01/2024-12/31/2024). Increase member engagement for currently pregnant African American BadgerCare Plus members who reside in Milwaukee County with an AODA claim code in the past two years within the Wisconsin Community Services Hub & Spoke Health Home Maternal Program from 0% on 02/01/2024 to 50% by 12/31/2024 (timeframe 03/01/2024-12/31/2024).	Improve member engagement in the community program Wisconsin Community Services Hub & Spoke Health Home Maternal Program for individuals living with substance use and other complex needs.
MercyCare Insurance Company	Childhood Immunization	Increase measurement year 2021 CIS Combo 10 rate 28.71% rate by 6.39% to bring it up to 35.10% for measurement year 2024.	• Telephonic outreach to parents of children between the ages of two and three months old to connect them to Children's Wisconsin for applicable services to address SDoH barriers which may prevent members from receiving preventive care.

HMO	PIP Topic	PIP Aim	PIP Interventions
			• Partner with Mercyhealth's Diversity, Equity, and Inclusion Committee and Joint Commission Health Equity Steering Committee to identify and provide education to physicians and other health plan and system partners.
	Provider and Member Demographic Parity	Increase rate of members over the age 18 who indicate that the staff at the clinic they typically receive care in met their racial, cultural, and language needs by 2% when surveyed for MY2024 in January of 2025, for a final rate of 97%.	• Increase the rates of providers with additional demographic data on file. • Improve the dissemination of the information. • Add it to the provider directory or providing education to members on how to request the data.
MHS Health Wisconsin	Reducing Health Disparities in Behavioral Health Measures	Improve HEDIS FUH rates for all SSI members (study population) from 55.83% in MY2022 to 57.83% in MY2024. Improve HEDIS Follow-up After Emergency Department Visit for Mental Illness (FUM) rates for all SSI members (study population) from 57.5% in MY2022 to 59.5% in MY2024.	• The behavioral health CHW will provide health coaching, care coordination, and social needs support for members diagnosed with a primary mental health diagnosis. • Promotion of digital mental health app that enables proactive management of members and a variety of evidence-informed techniques. • Expand partnership with Wisconsin Community Support for increased behavioral health support.
	Increase in Initial Health Needs Assessment for BadgerCare Plus Members	Improve the rate of Health Needs Assessment completion on new of BadgerCare Plus members (within 90 days of enrollment) from 3.1% in MY2023 to 15% in MY2024.	• Outreach using an in-house, predictive model called the NEST score to prompt targeted outreach to members. Members with the highest scores on this report will receive targeted outreach from a SDoH-focused CHW to complete an initial Health Needs Assessment, which includes an assessment of SDoH needs. • Members will have support in closing risk and gaps in care and will be able to gain access to incentives and rewards that come with closing those gaps in care. Including digital options for completion and reminders for members to fill out their assessment. • Stratifying the initial outreach NEST score will aid in targeting members who may not otherwise by prioritized for outreach.
Molina Healthcare of Wisconsin (MHWI)	SSI Cervical Cancer Screening (CCS): Language and Trauma Barriers	Increase the overall combined MHWI and My Choice Wisconsin (MCW) CCS rate for the SSI population from 56.08% to 59.85% in MY2024.	Implement interventions focused on trauma-informed care and transportation barriers and implement interventions to increase translation and interpreter access and reduce cultural barriers

HMO	PIP Topic	PIP Aim	PIP Interventions
			experienced by non-English speaking members through: • Conducting call campaigns in a member's preferred language. • Sending member education mailers, including trauma-informed care and transportation resources. • Collaborating with both providers and community-based organizations to better understand any barriers, including cultural and transportation barriers, that could result in CCS non-compliance and target intervention content accordingly.
	Increasing BadgerCare Plus Member Satisfaction Among Diverse Populations	Increase the percent of those who respond with a nine or 10 on the CAHPS Child Survey question, "Using any number from 0-10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?" from 67.8% in the MY2022 survey to 73.6%.	• Collate existing language data into actionable scorecard. • Evaluate existing resources and determine gaps for member education materials related to cultural and language resources. Develop materials based on gap analysis. • Enhance provider data within Molina's provider online directory. • Connect non-English speaking members with providers who speak or offer alternate languages. • Collaborate with CBOs to better understand and connect with our target population.
Network Health Plan (NHP)	Reduction in Health Disparities in Postpartum Care	Improve the Postpartum Care rate for all NHP BadgerCare Plus pregnant members (study population) from 63.90% in MY2022 to 65.90% in MY2024.	• Members who are identified by their Obstetric (OB) Screening Assessment as "high risk" and enroll in and stay engaged in OB case management will receive one $25 box of diapers upon engagement and then another upon postpartum visit attendance/completion of case management. • Utilize Baby Live Advice, a virtual platform that offers support and education from the beginning of maternity to infancy. • Expansion of Mom's Meals food delivery program.

HMO	PIP Topic	PIP Aim	PIP Interventions
	Addressing Social Needs in Rural Wisconsin	Improve the rate of completed SDoH assessments for BadgerCare Plus members living in rural counties from 3.1% in MY2023 to 15% in MY2024. Improve the rate of completed SDoH assessments for SSI members living in rural counties from 3.1% in MY2023 to 15% in MY2024.	• Targeted outreach to increase the overall amount of SDoH screening occurring in rural areas and overall. • Expanded SDoH partnerships with providers in smaller clinics to providers in rural counties. Partnerships will be pursued by Health Equity Program Manager and CHWs that are strategically placed in rural counties. • Optimization of digital options for members to complete SDoH screenings, specifically the member use of the FindHelp platform to complete an SDoH screener online through the health plan's website.
Quartz	Improving BadgerCare Plus Diabetes Control Rates	Improve BadgerCare Plus HEDIS Diabetes Control <8% rate: 1) Overall, from (204/411) 49.6% in 2022 to 54.6% in 2024. 2) For African American or Black members from (23/56) 41.1% in 2022 to 47% in 2024. 3) For Hispanic or Latino members from (14/32) 43.8% in 2022 to 49.4% in 2024.	• Increase enrollment in Quartz Type 2 Diabetes and Obesity Reversal Treatment for all BadgerCare Plus members with diabetes. • Offer Quartz diabetes registered nurse case management to African American members with a glycemic status 8% or greater. • Offer Quartz care coordination to Hispanic or Latino members without a glycemic status test in the MY.
	Improving BadgerCare Plus and Medicaid SSI Health Risk Assessment Completion Rates	BadgerCare Plus: 1) Overall: Increase the initial Health Risk Assessment completion rate for newly enrolled members (within 90 days of their Quartz effective date) from 4% (235/5,658) in 2023 to 14% in 2024. 2) Spanish Primary Language: Increase the initial Health Risk Assessment completion rate for newly enrolled members with a primary spoken language of Spanish (within 90 days of their Quartz effective date) from 2% (6/275) to 12% in 2024. Medicaid SSI: 3) Overall: Increase initial Health Risk Assessment completion rate for newly enrolled members (within 60 days of their Quartz effective date) from 31% (61/199) in 2023 to 38% in 2024.	To improve access to the Health Risk Assessment tool and increase the likelihood members will complete the assessment, Quartz will prioritize the following items in early 2024: • Translate the paper versions of our adult and child Health Risk Assessment into Spanish. • Update our online/digital Health Risk Assessment so it is available in Spanish. • Develop a robust marketing campaign and messaging strategy, also offered to Spanish speaking members in their primary language, that helps members understand the benefits of completing a Health Risk Assessment. • Offer a $25 gift card incentive drawing.

HMO	PIP Topic	PIP Aim	PIP Interventions
		4) Spanish Primary Language: Increase initial Health Risk Assessment completion rate for newly enrolled members with a primary spoken language of Spanish (within 60 days of their Quartz effective date) from 7% (1/15) in 2023 to 16% in 2024.	
Security Health Plan Wisconsin (SHP)	Hemoglobin A1c Control for Patients with Diabetes	Increase Black/African American SHP members who achieve good HbA1C control (<8%) from 42.86% in MY2022 to 52.3% HEDIS in MY2024 through targeted mailings and utilizing FindHelp, a social care and needs referral platform.	• Identify Medicaid BadgerCare Plus members with Type 1 or Type 2 diabetes and conduct a multi-channel outreach effort with targeted mailings. • Investigate potential digital health materials for this population. • Expand the partner clinic's screenings of social determinants of health more broadly and ultimately leverage FindHelp to address the patient's need. • Partner with a CBO that most aligns with our goals of supporting our members with diabetes, especially those who are non-white.
	SSI Care Management Engagement	Increase screen completion rate from 20% in 2023 to 50% in 2024 for SSI members who are not enrolled in a Medicare Advantage Plan.	• Identify the SSI population in the SSI care management program for screening completion. • Review and modify the screening assessment has been to increase member engagement. • Provide motivational interviewing training on an ongoing basis to assist the SSI care management team in how to engage with the SSI population using motivational interviewing techniques and strategies. • Send communication/letters to members enrolled in the SSI care management program that include more streamlined and efficient access to the SSI care management team by providing phone numbers for direct access to the team.
United Healthcare Community	Postpartum Care Disparities Reduction	Decrease the Index of Disparity for the HEDIS postpartum care measure for UHCCP WI BC+ members from 5.974 in MY2022 at baseline to less than 5.000 in MY2024.	Partner with FarmboxRX to provide fresh food boxes to Black or African American pregnant members experiencing food insecurity.

HMO	PIP Topic	PIP Aim	PIP Interventions
Plan (UHCCP)	Increasing Food Insecurity Screenings in Diabetic Members Residing in Milwaukee County	• Increase the percentage of BadgerCare Plus members that have diabetes and who reside in Milwaukee County that have been screened for food insecurity from 1.5% to 6.5%. • Increase the percentage of SSI members that have diabetes and who reside in Milwaukee County that have been screened for food insecurity from 43.6% to 48.6%.	• Conduct a phone outreach campaign to screen members for food insecurity. Additional outreach occurs in the clinical case management programs and will be focused on engaging members that are unable to be reached by clinical teams. • Partner with FarmboxRX to provide fresh food boxes to members in the target population who have a food need identified during screening. • Partner with Sherman Park Grocery Store to offer gift cards to members who reside in the Sherman Park neighborhood to be used on fresh fruits and vegetables and staples like eggs, dairy, canned foods, etc.

MCO Performance Improvement Projects

2024 Managed Care Organization (MCO) Performance Improvement Project (PIP) Topics and Aims

This table is posted to comply with 42 CFR 438.340(b)(3)(ii), which requires States to provide a description of the PIPs* being implemented annually in accordance with its quality assessment and performance improvement program.

Interested parties can contact the MCOs for more information about these projects. Contact information can be found in the General Information section on the Family Care, Family Care Partnership, and PACE: Program Operations for Managed Care Organizations page at https://www.dhs.wisconsin.gov/familycare/mcos/index.htm.

MCO	PIP Topic	PIP Aim
Community Care, Inc. (CCI)	Diabetic Eye Exams	Can targeted education by interdisciplinary team staff on the importance of annual eye exams with members diagnosed with Type 1 or Type 2 diabetes in all pilot regions increase the compliance of eye exams from 23% to 43% from 04/01/2024 through 11/30/2024?
	Member Advisory Committee Expansion	During 4/1/24 through 11/30/24, can an educational campaign targeting Program of All-Inclusive Care for the Elderly (PACE) members enrolled at Trinity Woods Convent allow CCI to sustain a new quarterly in-person Member Advisory Committee with 18% of the PACE members at the facility with 95% confidence? During 4/1/24 through 11/30/24 can an educational campaign targeting Spanish speaking members enrolled in the Family Care (FC) and Family Care Partnership (FCP) programs allow CCI to sustain a new quarterly virtual Member Advisory Committee of 5% of the Spanish speaking membership with 95% confidence?

MCO	PIP Topic	PIP Aim
Independent Care Health Plan (iCare)	Diabetes Management	Through the nurse practitioner's efforts and the interdisciplinary team's participation in a diabetes management learning, the documentation of hemoglobin (Hb) A1c laboratory testing within the last 12-months will increase from 29.03% as of January 17th, 2024 (Baseline) to 40% by November 1, 2024 (Repeat) for enrolled members with diagnosis of diabetes.
	Establishing Caregiver Strain Scores	Through implementation of the modified caregiver strain index assessment and standardized documentation for scoring, the project aims to increase the percentage of caregiver strain scores obtained from 0% on 02/01/2024 to 60% by 11/15/2024 for eligible iCare FCP members with a Dementia/Alzheimer's disease diagnosis and/or vulnerable high-risk member, resides at home (non-residential facility) alone/ with family/spouse/partner/friend, per Long Term Care Functional Screen (LTCFS) and has as a family, friend, or partner as the caregiver.
Inclusa, Inc.	Diabetes Management	Through the nurse care manager's participation in an evidence-based diabetes management learning, will the comprehensiveness of the member assessment be improved, as evidenced by the documentation of a received HbA1c laboratory test within the last 12 month time period, from 78% as of February 14, 2024 (Baseline) to 90% by November 1, 2024 (Repeat) for enrolled members with a diagnosis of diabetes and a comprehensive member assessment review due in June, July, or August 2024?
	Long Term Care Functional Screen Tool Use as Foundation of Comprehensive Assessment	Will a detailed instructional training program on the use of the LTCFS Quality Review communication tool for interdisciplinary teams and their managers improve the use of the LTCFS as a foundation for a comprehensive member assessment, as evidenced by an increased closure rate of the LTCFS Quality Reviews for enrolled members from 68% (baseline) of those due in August and September of 2023 to 90% or greater (repeat) of those due in August and September of the 2024 project year (repeat)?
Lakeland Care, Inc.	Blood Pressure Monitoring: Improving Member Participation	Does providing education and member resources to registered nurse care managers (RNCMs) about blood pressure monitoring (intervention) increase the number of Target Group 1 members with a blood pressure obtained by the RNCM and documented in the member record from 26.4% (implementation projection contains 6-month timeframe of July – December 2023) to 31.4% from May 1, 2024, to October 31, 2024?
	Supporting Member Choice and Preferences with Advanced Directives	Does providing education and resources to care managers about advance directives and the importance of maintaining current copies in the member record (project intervention) increase the number of Target Group 1 members' activated powers of attorney for health care scanned into the member record from 15.0% (implementation projection measured as of December 2023) to 20.0% from May 1, 2024 to October 31, 2024 (final project data to be measured October 31, 2024)?
My Choice Wisconsin (MCW)	Improve Self-management Behaviors of Members with Diabetes	Following the care management training on comprehensive diabetic care with targeted blood sugar testing focus and new diabetic care member resource(s), will the percentage of MCW FC and FCP members with diabetes who receive education on targeted comprehensive diabetic care increase from 0% (Baseline measurement period (MP) 5/1/2023 - 5/31/2023) to 85% (Outcome MP 5/1/2024 - 5/31/2024)? Will comprehensive diabetic care education with targeted blood sugar testing focus and diabetic care member resource(s) with MCW FC and FCP members with diabetes increase the percentage of

MCO	PIP Topic	PIP Aim
		members that report testing their blood sugar from 66.7% (Baseline MP 5/1/2023 - 11/30/2023) to 71.9% (Outcome MP 5/1/2024 - 11/30/2024)?
	Increasing Advance Directive Completion for Hispanic My Choice Wisconsin Family Care and Partnership Members	Through implementation of advance directive and healthcare power of attorney (HCPOA) staff training and availability of updated and additional HCPOA resources, the project aims to increase the percentage of FC and FCP members (without a legal guardian, self-reported of Hispanic ethnicity, and continuously enrolled 5/1/2024-10/31/2024) recorded as having completed HCPOA paperwork from 44.4% (5/1/2023-10/31/2023) to 49.5% (5/1/2024-10/31/2024).

*MCO PIP proposals do not include details about the interventions being implemented beyond a general description included in the PIP aim statement. DHS intends to request information about proposed interventions in future years.

Quality Strategy Public Comments

The draft Quality Strategy document was made available September 23, 2024, to October 25, 2024, for comment by partners and the public through a number of outreach efforts. These outreach efforts include:

- Presentation to advisory committees and councils
- Presentation to the Medical Care Advisory Committee
- Tribal nation consultation
- Publication on the DHS website
- GovD email notice

Meeting minutes from the Medical Care Advisory Committee discussion on the Quality Strategy are publicly available (link to be added). Following the 30-day public comment period, all feedback was reviewed. Verbatim comments are presented below.

A number of themes were identified from review of the [##] public comments received, based on common pieces of feedback expressed by multiple comment submitters. Comments are numbered in Table # and associated with common themes below:

- Theme # (Comment numbers #, #, #)
- Theme # (Comment numbers #, #, #)
- Theme # (Comment numbers #, #, #)
- Theme # (Comment numbers #, #, #)

TABLE 1 2024 MEDICAID MANAGED CARE QUALITY STRATEGY PUBLIC COMMENTS

1	TBD
2	TBD

MCO Accreditation Crosswalk

This Accreditation Crosswalk was prepared by DHS and its EQRO, MetaStar, in order to demonstrate to CMS how the NCQA accredited organizations are deemed and therefore do not require a review of their compliance with Medicaid Managed Care rules. As instructed by CMS, this crosswalk is updated for requirement changes and at minimum every three years to align with the DHS' Medicaid Managed Care Quality Strategy. The MCO Accreditation Deeming Plan is updated to compare NCQA accreditation requirements with the federal Managed Care requirements for Medicaid MCOs (42 Code of Federal Regulations (C.F.R.) section 438) in order to determine gaps between requirements. In Wisconsin, only BadgerCare Plus HMOs and Medicaid SSI HMOs, including the parent company to the Care4Kids PIHP, are accredited by NCQA and are deemed as meeting any standards below.

NCQA offers an optional Medicaid (MED) accreditation module. The MED module is an addition to the general NCQA accreditation and addresses many of the remaining gaps between the federal Managed Care requirements and NCQA accreditation standards. The MED standards are included in the table below. The MCO must have elected to include this add on module as part of their accreditation in order for the applicable requirements to be satisfied through NCQA when only MED standards are identified.

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

Managed Care Organization (MCO) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
M1	Availability of services Medicaid: 42 C.F.R. § 438.206 (availability of services) and 42 C.F.R. § 10(h) (provider directory)	The MCO maintains and monitors a network of appropriate providers, sufficient to provide adequate access to all services under the contract. The information is provided to members through a Provider	1	Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.	NET 1 MED 3 MED 12
			2	Provide female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.	NET 1 MED 1

Managed Care Organization (MCO) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	2024-2025 BC+ and Medicaid SSI – DHS Contract	Directory maintained by the MCO.	3	Provide for a second opinion from a network provider or arranges for the member to obtain one outside the network, at no cost to the member.	MED 1
			4	Provide necessary services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these services out of network for the member, for as long as the MCO's provider network is unable to provide them.	MED 1
			5	Coordinate with out-of-network providers for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the network.	MED 1
			6	Demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.	NET 1
			7	Provider Directory Distribution MCOs must: a) Post a provider directory on their website for members, network providers, and DHS to access. b) Make the provide directory available in paper form upon request and at no cost to the member. c) Update the provider directory at least monthly but no later than 30 days after receiving updated provider information. d) Have a machine-readable file and format available on the MCO's website.	None
M2	Furnishing of services and timely access Medicaid: 42 C.F.R. §	The MCO must ensure timely access to care and services.	1	Require network providers meet standards for timely access to care and services, considering the urgency of the need for services.	NET 2
			2	Ensure network providers offer hours of operation that are no less than the hours of operation offered to commercial	MED 1

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Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	438.206(c)(1): Furnishing of services and timely access 2024-2025 BC+ and Medicaid SSI – DHS Contract			members or Medicaid FFS. The MCO must ensure appointment and facility wait time standards do not discriminate against members.	
			3	Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.	MED 1
			4	Provide medically necessary, high-risk prenatal care within two weeks of the member's request for an appointment, or within three weeks if the request is for a specific MCO provider, who is accepting new patients.	MED 1
			5	Establish mechanisms to ensure compliance by network providers.	QI 2 CR 5
			6	Monitor network providers regularly to determine compliance.	QI 2 CR 5
			7	Take corrective action if there is a failure to comply by a network provider.	QI 2 CR 5
M3	Access and cultural considerations Medicaid: 42 C.F.R. § 438.206(c)(2): Furnishing of services and cultural considerations 2024-2025 BC+ and Medicaid	The MCO must participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds,	1	The MCO must incorporate the National Culturally and Linguistically Appropriate Services (CLAS) Standards into organizational practices and the delivery of services with a focus on care management services for members.	NET 1 ME 2 MED 12
			2	The MCO must encourage and foster CLAS Standards among providers and increase diversity in the MCO's network to respond appropriately to member's linguistic and cultural needs. The MCO must permit members to choose providers from the MCO's network based on linguistic and/or cultural needs. The MCO must permit members to change primary care providers based on the provider's ability to provide services in a culturally and linguistically responsive manner.	NET 1 ME 2 MED 12

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Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	SSI – DHS Contract	disabilities, and regardless of sex.	3	MCOs must ensure members are linked to a primary care provider or primary care clinic that provides culturally appropriate care. Specifically, the provider must be able to relate to the member and provide care with sensitivity, understanding, and respect for the member's culture.	NET 1 ME 2 MED 12
M4	Assurances of adequate capacity and services Medicaid: 42 C.F.R. § 438.207: (Assurances of adequate capacity and services) and 42 C.F.R. § 438.68 (Network adequacy standards) 2024-2025 BC+ and Medicaid SSI – DHS Contract	Network Adequacy Validation	N/A	The Network Adequacy Validation occurs separate from the Compliance with Standards review.	N/A
M5	Coordination and continuity of care for all enrollees Medicaid: 42 C.F.R. § 438.208:	The MCO must implement procedures to deliver care to and coordinate services for all MCO members.	1	Ensure that every member has a primary care provider or a primary care clinic responsible for coordinating the services accessed by the member: a) The MCO must have a process in place to link each BC+ and Medicaid SSI member with a primary care provider, a primary care clinic, or a specialist when appropriate based on the preferences and health care needs of the member.	NET 1 NET 2 PHM 5 MED 5

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Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	Coordination and continuity of care Confidentiality 42 C.F.R. § 438.224 2024-2025 BC+ and Medicaid SSI – DHS Contract			b) The process shall include a defined method to notify the member of their primary care provider and how to contact the provider. c) The MCO shall allow members an initial choice of primary care provider or primary care clinic prior to designation.	
			2	The MCO must coordinate the services it provides to members: a) Between settings of care, including appropriate discharge planning for hospital or institutional stays. Upon notification of a change in setting of care, the MCO is responsible for coordination with the hospital or institution staff. b) With services provided by another MCO. c) With services a member receives through Medicaid Fee for Service. d) With services a member receives through community and social support providers. e) With Medicare provided services as applicable.	QI 3 MED 5
			3	The MCO must make a best effort to conduct an initial screening of each member's needs, within 90 days of MCO enrollment for all new BadgerCare Plus members, and within 60 days of enrollment for new Medicaid SSI members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. a) Foster Care Medical Home Only: The comprehensive initial health assessment is required for all children entering out-of-home care and must occur within 30 days of enrollment.	MED 6
			4	Share with other MCOs serving the member the results of its identification and assessment of any member with	MED 6

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				special health care needs so that those activities need not be duplicated.	
			5	Ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.	MED 5
			6	Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 C.F.R. parts 160 and 164 subparts A and E, to the extent that they are applicable.	MED 4
M6	Additional coordination and continuity of care requirements Enrollees with Special Health Care Needs 42 C.F.R. § 438.208: Coordination and continuity of care 2024-2025 BC+ and Medicaid SSI –DHS Contract	The State must implement mechanisms to identify persons who need LTSS or persons with special health care needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms— (i) Must be specified in the State's quality strategy under § 438.340. (ii) May use State staff, the State's enrollment broker, or	1	The MCO must implement mechanisms to comprehensively assess each member with special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.	None
			2	The MCO must produce a treatment or service plan for members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be: a) Developed by appropriately qualified staff, and in consultation with any providers caring for the member. b) Developed by a person trained in person-centered planning using a person-centered process and plan. c) Approved by the MCO in a timely manner, if this approval is required by the MCO. d) In accordance with any applicable State quality assurance and utilization review standards. e) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the	MED 5

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Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
		the State's MCOs, PIHPs and PAHPs.		member's circumstances or needs change significantly, or at the request of the member.	
			3	For SSI Managed Care Only: The MCO must have an appropriate care management infrastructure to serve the SSI Managed Care population: a) The MCO must have a sufficient number of adequately trained care management staff to meet individual member needs. b) As part of the care management infrastructure, the MCO must also have a WICT that is capable of rapidly mounting an intensive intervention and share a caseload for members identified by the MCO with the highest needs and to serve as a consultative resource for other Care Management staff.	MED 1
			4	For SSI Managed Care Only: The care management team must collect, maintain, and update all relevant information to conduct needs-stratification and to develop the comprehensive care plan.	MED 1
			5	For SSI Managed Care Only: MCOs must use individual member-level needs stratification as an input for developing individual care management plans, and for using those plans to provide care management for the members. The MCO must also: a) Periodically reassess whether the members are assigned to the most appropriate strata, based on changes in their overall medical and social needs. b) Continuously monitor and enhance MCO's stratification methods for improving the health outcomes for members.	MED 1
			6	As part of the comprehensive care plan development, the care management team or the WICT, in coordination with the member, must create an evidence-based plan of care.	MED 1

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Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
M7	Disenrollment Medicaid: 42 C.F.R. § 438.56: Disenrollment: Requirements and limitations 2024-2025 BC+ and Medicaid SSI – DHS Contract	The MCO must comply with requirements for member disenrollment.	1	Voluntary Disenrollment: The MCO must direct all members with disenrollment requests to the Enrollment Specialist for assistance.	None
			2	A member may voluntarily disenroll from an MCO for any reason when the member is not in the lock-in period. Voluntary disenrollment requests must come from the member, the member's family, or legal guardian.	None
			3	A member may only disenroll from an MCO when in their lock-in period for the following reasons: a) Upon automatic reenrollment under 42 C.F.R. § 438.56(c) the temporary loss of BadgerCare Plus and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period. b) If an MCO does not, because of moral or religious objections, cover the service the member seeks. The MCO must notify the Department, at the time of certification, of any services that they would not provide due to moral or religious objections. c) If the member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk. d) The SSI MCO fails to complete the assessment and care plan during the first 90 days of enrollment; and is able to demonstrate a good faith process to complete the assessment, the voluntary disenrollment period will be extended an additional 30 days. e) Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack	None

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Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				of access to providers experienced in dealing with the member's care needs.	
			4	System Based Disenrollments System based disenrollments happen automatically in the system as a result of changes to the member's eligibility. If an MCO believes a member should have had a system-based disenrollment but has not, the MCO may request disenrollment through the Department's MCO Enrollment Specialists. Reasons for a system-based disenrollment include: a) Loss of BadgerCare Plus and/or Medicaid SSI Eligibility b) Out-of-Service Area Disenrollment c) Medicare Beneficiaries (BadgerCare Plus Only) d) Inmates of a Public Institution e) Waiver Programs f) Death g) Out of State Moves h) Change in Member Circumstance, including member moves out of service area and member death	None
			5	Change in member circumstance: When a member's change is circumstance has been identified and verified by the MCO, the MCO must provide prompt written notification and proof of the change to DHS or the appropriate entity as designated by DHS. Changes in circumstance include: a) Change in the enrollee's residence when the enrollee is no longer in the MCO's service area. b) The death of an enrollee.	None

Managed Care Organization (MCO) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
			6	The MCO must direct all members with exemption requests to the Enrollment Specialist for assistance. Reasons for exemptions include: a) Just Cause b) Nursing Home c) Commercial Insurance d) Experimental Transplant e) Admission to Birth to 3 (BadgerCare Plus Only) f) Native American g) Continuity of Care h) Voluntary (SSI Medicaid Plans – Dual Eligible Members with Medicaid and Medicare or MAPP members) i) Long Term Complex Care (BadgerCare Plus and SSI Medicaid Plans) j) Distance k) Low Birth Weight l) High Risk Pregnancy	None
M8	Coverage and authorization of services Medicaid: 42 C.F.R. § 438.210(a–e)*: Coverage and authorization of services, including 42 C.F.R. § 440.230 Sufficiency of amount, duration, and scope; 42	MCO policies and procedures for service authorizations will comply with required standards.	1	The MCO must: a) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. b) Consult with the requesting provider for medical services when appropriate.	UM 1 UM 2 MED 9
			2	The MCO: a) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished to members in Medicaid fee for service. b) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	UM 1 UM 2

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Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	C.F.R. § Part 441, Subpart B: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21;* and 42 C.F.R. § 438.114, Emergency and post-stabilization services 2024-2025 BC+ and Medicaid SSI – DHS Contract		3	Within the time frames specified, the MCO must give the member and the requesting provider written notice of: a) The decision to deny, limit, reduce, delay or terminate a service along with the reasons for the decision. b) The member's grievance and appeal rights, as detailed in the Member Grievances and Appeals Guide. c) Denial of payment, at the time of any action affecting the claim.	UM 7 MED 9
			4	Time frame for decisions: For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service. One extension of up to 14 days may be allowed if either of the following conditions are met: a) The member or the provider requests an extension. b) The MCO justifies the need for additional information and how the extension is in the member's interest.	UM 5
			5	Expedited authorization decisions a) For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service. b) The MCO may extend the 72-hour time period by up to fourteen (14) calendar days if the member requests	UM 5

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Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				an extension, or if the MCO justifies the need for more information.	
			6	Emergency and Post-Stabilization of Services The MCO is responsible for coverage and payment of emergency services and post stabilization care services. a) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP, PCCM or PCCM entity; and, b) May not deny payment for treatment obtained under either of the following circumstances: i. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in Article I.A.52.a.i-iii. of the definition of Emergency Medical Condition) ii. For a member who had MCO approval to seek emergency services.	MED 9
			7	Emergency and Post-Stabilization of Services: The MCO may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, or MCO of the member's screening and treatment within ten (10) days of presentation for emergency services.	None
			8	Emergency and Post-Stabilization of Services: A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	MED 9

Managed Care Organization (MCO) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
			9	Emergency and Post-Stabilization of Services: The MCO in coordination with the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.	None
M9	Information requirements for all enrollees Medicaid: 42 C.F.R. § 438.100(b)(2)(i) Enrollee right to receive information in accordance with 42 C.F.R. § 438.10: Information requirements 2024-2025 BC+ and Medicaid SSI – DHS Contract	The MCO provides information to members in a manner and format that is easily understood and is readily accessible.	1	Written materials that are critical to obtaining services, including at minimum: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices must: a) Be available in the prevalent non-English languages for the MCO's Rate Region. b) Be made available in alternative formats and through the provision of auxiliary aids and services upon request of the member or potential member at no cost. c) Include conspicuously visible taglines in the prevalent non-English languages in the State, explaining the availability of written translations or oral interpretation to understand the information provided, information on how to request auxiliary aids and services. d) Include the toll-free telephone number of the entity providing choice counseling services.	ME 2 ME 7 UM 3 MED 12
			2	Language and Format a) MCOs must make oral interpretation in any language available to members and potential members. b) Oral interpretation shall be free of charge to members and potential members.	NET 1 ME 2 ME 7 UM 3 MED 12 MED 13

Managed Care Organization (MCO) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
			3	MCOs must make written translation available in each prevalent language	NET 1 ME 2 ME 7 UM 3 MED 12 MED 13
			4	Auxiliary aids, such as TTY/TDY and American Sign Language (ASL), must be available to members and potential members.	NET 1 ME 2 ME 7 UM 3 MED 12 MED 13
			5	The MCO may provide, member information required in 42 C.F.R. § 438.10 electronically only if all of the following are met: a) The format is readily accessible. b) The information is placed in a location on the MCO, website that is prominent and readily accessible. c) The information is provided in an electronic form which can be electronically retained and printed. d) The information is consistent with the content and language requirements of 42 C.F.R. § 438.10. e) The member is informed that the information is available in paper form without charge upon request and the MCO provides it upon request within five (5) business days.	NET 1 ME 2 ME 7 UM 3 MED 12 MED 13
			6	All written materials must:	NET 6

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Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				a) Be in easily understood language and format. b) Use a font size no smaller than 12 point. c) Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of the member or potential member with disabilities or limited English proficiency.	ME 2 ME 7 UM 3 MED 12 MED 13
			7	Notification to Members MCOs must notify members and potential members: a) That oral interpretation is available for any language and written translation is available in prevalent non-English languages. b) That auxiliary aids and services are available upon request and at no cost for members with disabilities. c) How to access oral interpretation and auxiliary aids and services.	ME 2 MED 13
			8	Information for all members The MCO must make a good faith effort to give written notice of termination of a network provider to each member who received primary care from, or was seen on a regular basis by, the terminated provider. The MCO must provide the member notice by the later of 30 calendar days prior to the effective date of the termination or fifteen (15) calendar days after receipt or issuance of the termination notice.	NET 4
			9	Member Handbook: Within 10 days of final enrollment notification to the MCO, the MCO must provide a hardcopy member handbook to new members.	ME 2 MED 1 MED 8 MED 12

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			10	Online Provider Directory The MCO must post a provider directory on their website for members, network providers, and the Department to access. The file must be updated at least monthly with hard copies available upon request from a member. The file must include the following information: a) Provider's name b) Provider's Street address(es) c) Provider's phone number(s) d) Provider's gender e) Provider's website (if available) f) Provider's Specialty g) If the provider is accepting new patients h) Provider's cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office i) Provider completed cultural competence training j) Accommodations for people with physical disabilities, including offices, exam rooms, and equipment k) Provider's hospital affiliation l) Provider's medical group affiliation m) Provider's board certification	NET 5 MED 14
M10	Enrollee right to receive information on available treatment options. Medicaid: 42 C.F.R. § 438.100(b)(2)(iii)	Members will receive information on available provider options. MCOs will not restrict a provider acting within the lawful scope of practice, from advising or advocating	1	Members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	ME 1 MED 12
			2	Choice of Network Provider: The MCO must offer each member covered under this Contract the opportunity to choose a primary care provider affiliated with the MCO, to the extent possible and appropriate. If the MCO designates a PCP to members, then the MCO must notify	ME 1 MED 12

Managed Care Organization (MCO) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	Enrollee right to receive information on available treatment options and alternatives including requirements of 42 C.F.R. § 438.102: Provider-enrollee communications 2024-2025 BC+ and Medicaid SSI – DHS Contract	on behalf of a member.		members of the designation. If the MCO has reason to lock in a member to one primary provider in cases of difficult case management, the MCO must submit a written request in advance of such lock-in to the MCO's managed care analyst. Culturally appropriate care in this section means care by a provider who can relate to the member and who can provide care with sensitivity, understanding, and respect for the member's culture.	
			3	An MCO may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his/her patient, including any of the following: a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. b) Any information the member needs in order to decide among all relevant treatment options. c) The risks, benefits, and consequences of treatment or non-treatment. d) The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	ME 1 MED 12
M11	Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint	The MCO will have policies guaranteeing each member's rights and advance directives, which include the right to participate in	1	The MCO must have written policies guaranteeing each member's rights and share those written policies with staff and affiliated providers to be considered when providing services to members.	None
			2	Members have the right to: a) Receive information in accordance with 42 C.F.R. § 438.10.	ME 1 MED 12

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	Medicaid: 42 C.F.R. § 438.100(b)(2)(iv) and (v): Enrollee right to: - participate in decisions regarding his or her care, including the right to refuse treatment; - Be free from any form of restraint as specified in other Federal regulations and related: 42 C.F.R. § 438.3(j): Advance directives 2024-2025 BC+ and Medicaid SSI – DHS Contract	decisions regarding his or her care, to be free from any form of restraint, and the right to refuse treatment.		b) Be treated with respect and with due consideration for his or her dignity and privacy. c) Participate in decisions regarding his or her health care, including the right to refuse treatment. d) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. e) Request and receive a copy of his or her medical records, and request that they be amended or corrected. f) Be furnished health care services in accordance with 42 C.F.R. § 438.206 through 438.210. g) Be free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its network providers treat the enrollee.	
			3	The MCO must have written restraint policies guaranteeing each member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.	None
			4	Advance Directives The MCO must maintain written n policies and procedures concerning advance directives which must, at a minimum, do the following: a) Clarify any differences between any MCO conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives. b) Describe the range of medical conditions or procedures affected by the conscience objection.	MED 1

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				c) Document in the individual's medical record whether or not the individual has executed an advance directive. d) Not discriminate in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive. e) Ensure compliance with the requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives. f) Provide education for staff and the community on issues concerning advance directives. g) Providing staff training about MCO specific policies and procedures related to advance directives.	
M12	Compliance with other Federal and state laws Medicaid: 42 C.F.R. § 438.100(d): Compliance with other federal and state laws 2024-2025 BC+ and Medicaid SSI – DHS Contract	The MCO will comply with applicable Federal and State laws for the protection of member rights.	1	The MCO must comply with any applicable Federal and State laws, including those identified in 42 C.F.R. § 438.100, that pertain to member rights.	None

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Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
M13	Provider Selection Medicaid: 42 C.F.R. § 438.214: Provider selection 2024-2025 BC+ and Medicaid SSI – DHS Contract	The MCO must have a written process for the selection and periodic evaluation of qualified providers. The MCO is responsible for ensuring all applicable provider requirements are met at initial contracting and throughout the duration of the contract.	1	The MCO must have written policies and procedures for provider selection and qualifications. a) For each practitioner, including each member of a contracting group that provides services to the MCO's members, initial credentialing must be based on a written application, primary source verification of licensure, disciplinary status, eligibility for payment under BadgerCare Plus and/or Medicaid SSI. b) The MCO's written policies and procedures must identify the circumstances in which site visits are appropriate in the credentialing process.	CR 1 CR 2
			2	Credentialing and Recredentialing requirements Each MCO must follow a documented process for credentialing and recredentialing of network providers.	CR 1 CR 2
			3	The MCO must periodically monitor (no less than every three years) the provider's documented qualifications to ensure that the provider still meets the MCO's specific professional requirements.	CR 1 CR 2
			4	The MCO must also have a mechanism for considering the provider's performance. The recredentialing method must include updating all the information (except medical education) utilized in the initial credentialing process. Performance evaluation must include information from the QAPI system, reviewing member complaints, and the utilization management system.	CR 1 CR 2
			5	If the MCO delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity.	CR 1 CR 2
			6	The MCO must have a formal process of peer review of care delivered by providers and active participation of the	CR 1

Managed Care Organization (MCO) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				MCO's contracted providers in the peer review process. This process may include internal medical audits, medical evaluation studies, peer review committees, evaluation of outcomes of care, and systems for correcting deficiencies. The MCO must supply documentation of its peer review process upon request.	CR 2
			7	The MCO must have written policies that allow it to suspend or terminate any provider. The MCO must have a written appeal process available to providers that conforms to the requirements of the HealthCare Quality Improvement Act of 1986 (42 USC 11101 etc. Seq.).	CR 1 CR 2
			8	The MCO must notify DHS OIG and the Managed Care Analyst when it terminates a provider for cause. The MCO must report to other entities as required by law (42 USC 11101 et. Seq.).	CR 1 CR 2
			9	The MCO must determine and verify at specified intervals that: a) Each provider, other than an individual practitioner is licensed to operate in the state, if licensure is required, and in compliance with any other applicable state or federal requirements; and b) The MCO verifies if the provider claims accreditation or is determined by the MCO to meet standards established by the MCO itself.	CR 1 CR 2
			10	The selection process must not discriminate against providers such as those serving high-risk populations or specialize in conditions that require costly treatment. The MCO must have a process for receiving advice on the selection criteria for credentialing and recredentialing practitioners in the MCO's network.	CR 1 CR 2

Managed Care Organization (MCO) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				If the MCO declines to include groups of providers in its network, the MCO must give the affected providers written notice of the reason for its decision.	
			11	Excluded Providers The MCO may not employ or contract with providers debarred or excluded in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.	MED 1
M14	Sub-contractual relationships and delegation Medicaid: 42 C.F.R. § 438.230: Sub contractual relationships and delegation 2024-2025 BC+ and Medicaid SSI – DHS Contract	The MCO must oversee and be accountable for functions and responsibilities that it delegates to any subcontractor. The MCO must monitor the subcontractor's performance and take corrective action if needed. Subcontractor means an individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly	1	There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate, or out of compliance with HIPAA privacy or security requirements.	CR 8 ME 8 UM 13 QI 5 MED 2
			2	Before any delegation, the MCO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.	CR 8 ME 8 UM 13 QI 5 MED 2
			3	The MCO shall monitor the subcontractor's performance on an ongoing basis and subject the subcontractor to formal review at least once per contract period.	CR 8 ME 8 UM 13 QI 5 MED 2

Managed Care Organization (MCO) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
		to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP.	4	If the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor shall take corrective action.	CR 8 ME 8 UM 13 QI 5 MED 2
			5	If the MCO delegates selection of providers to another entity, the MCO retains the right to approve, suspend, or terminate any provider selected by that entity.	CR 8 ME 8 UM 13 QI 5 MED 2
M15	Practice Guidelines Medicaid: 42 CFR. 438.236: Practice guidelines 2024-2025 BadgerCare Plus and Medicaid SSI – Wisconsin Department of Health Services Contract	The MCO adopts practice guidelines based on needs of members as required.	1	The MCO must develop or adopt best practice guidelines in accordance with 42 C.F.R. § 438.236 (b) and meet the following requirements: a) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field. b) Consider the needs of the MCO members. c) Are adopted in consultation with network providers. d) Are reviewed and updated periodically as appropriate.	MED 2
			2	Decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply must be consistent with the guidelines.	MED 2
			3	The MCO must disseminate the guidelines to all providers and, upon request, to members and potential members.	MED 2
M16	Health information systems	The MCO maintains a health information system that collects,	Information Systems	N/A	The Information Systems

Managed Care Organization (MCO) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	Medicaid: 42 C.F.R. § 438.242 Appendix A: Information Systems Capabilities Assessment 2024-2025 BC+ and Medicaid SSI – DHS Contract	analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment (for other than loss of Medicaid eligibility).	Capabilities Assessment		Capabilities Assessment occurs separate from the Compliance with Standards review.

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
G1	Grievance Systems Medicaid: 42 C.F.R. § 438.228: Grievance and appeal systems. 2024-2025 BC+ and Medicaid	The MCO has a grievance and appeal system in place that includes an internal grievance process, an appeal process, and access to the state's Fair Hearing system.	1	The MCO must have a grievance and appeal system in place for members: a) Ensure that members have the option to appeal any adverse benefit determination, or file a grievance expressing their dissatisfaction about any matter other than an adverse benefit determination, to the Board of Directors of the MCO. b) The MCO Board of Directors may delegate the authority to review grievances and appeals to the MCO grievance appeal committee, but the delegation must be in writing.	ME 2 ME 7 UM 5 UM 8 MED 10

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	SSI – DHS Contract HMO and PIHP Member Grievances and Appeals Guide, updated February 2023. 4 General Requirements 4.1 Grievance and Appeal System		2	Have written policies and procedures that detail what the grievance and appeal system is and how it operates.	MED 10
			3	Identify a contact person in the MCO to receive grievances and appeals and be responsible for routing and processing.	None
			4	Inform members about the existence of the grievance and appeal processes and how to use them.	ME 7
			5	Attempt to resolve issues and concerns without formal hearings or reviews whenever possible. When a member presents a grievance or appeal, the member Advocate must attempt to resolve the issue or concern through internal review, negotiation, or mediation, if possible.	None
G2	General requirements Medicaid: 42 C.F.R. § 438.402: General requirements 2024-2025 BC+ and Medicaid SSI – DHS Contract HMO and PIHP Member Grievances and Appeals Guide, updated February 2023. 4	Member's authority, process and timing to file grievances and appeals.	1	The MCO may have only one level of appeal for members.	UM 8
			2	A member may file a grievance and request an appeal with the MCO. A member may request a State fair hearing only after receiving notice that the adverse benefit determination has been upheld by the MCO.	ME 7 MED 10
			3	A provider or an authorized representative may request an appeal, file a grievance, or request a State fair hearing on behalf of a member, provided there is documented consent from the member.	None
			4	A member may file a grievance with the MCO at any time.	MED 10
			5	A member has 60 calendar days from the date on the adverse benefit determination notice to file a request for an appeal to the MCO.	UM 8

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	General Requirements 4.2 Level of Appeals; 4.3 Filing Requirements; 4.4 Member Filing Timeframes; 4.5 Procedures		6	The member may file a grievance either orally or in writing. The member must file a grievance with the MCO. The date of the MCO's receipt of the member's oral or written grievance request is the start date of the acknowledgement and decision time frames.	MED 10
			7	The member may request an appeal either orally or in writing. The date of the MCO's receipt of the member's oral or written appeal request is the start date of the acknowledgement and decision time frames.	MED 10
G3	Timely and Adequate Notice of Adverse Benefit Determination Medicaid: 42 C.F.R. § 438.404: Timely and adequate notice of adverse benefit determination. 2024-2025 BC+ and Medicaid SSI – DHS Contract	MCO requirements for the content and timing of Notices of Adverse Benefit Determination.	1	The initial notice must explain the following: a) The adverse benefit determination the MCO has made or intends to make. b) The reasons for the adverse benefit determination and the right of the member to be provided reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination free of charge. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. c) The member's right to request an appeal of the MCO's adverse benefit determination, including information on exhausting the MCO's one level of appeal described. d) The procedures for exercising the rights specified below. e) The circumstances under which an appeal process can be expedited and how to request it, including the fact that an expedited timeframe requires a medical provider or the MCO to verify that delay can be a health risk.	UM 7

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				f) The member's right to have benefits continue while the appeal resolution is pending, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services. g) The member's right to have a representative assist at any point in the grievance or appeal process including reviews or hearings, and how to request that assistance. h) The member's right to present "new" information before or during the grievance and appeal process including reviews or hearings. i) The fact that retaliatory action will not be taken against a member, a member's authorized representative or a provider who appeals the MCO's decision. j) The fact that the member can receive help filing a grievance or appeal by calling the member Advocate, the Ombuds, or the SSI External Advocate. k) The address and telephone number of the member Advocate and Ombuds. The External Advocate must also be listed for Medicaid SSI members.	
			2	For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO must send (mail) a notice at least ten (10) days before the date of action (unless the situations detailed in G3.3 occur).	MED 9
			3	For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO may send a notice not later than the date of action if any of the following occur: a) The MCO has factual information confirming the death of a member.	MED 9

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				b) The MCO receives a clear written statement signed by a member that the member no longer wishes services or gives information that requires termination or reduction of services and indicates understanding that this must be the result of supplying that information. c) The member has been admitted to an institution and has become ineligible under the plan for further services. d) The member's whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address. e) The MCO establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth. f) A change in the level of medical care is prescribed by the member's physician. g) The notice involves an adverse determination made with regard to the preadmission screening requirements of §1919(e)(7) of the Social Security Act. h) The member in a facility will be transferred or discharged in less than ten (10) days as a result of individual health and safety concerns; improvement of health, urgent medical needs, or the member has not resided in the nursing facility for 30 days.	
			4	The agency may shorten the period of advance notice to 5 days before the date of action if both of the following conditions are met: a) The agency has facts indicating that action should be taken because of probable fraud by the member. b) The facts have been verified, if possible, through secondary sources.	MED 9

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
			5	The MCO must mail the notice within the following timeframes for denial of payment, at the time of any action affecting the claim.	UM 5 UM 8 UM 9
			6	The MCO must mail the notice within the following time frames for standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within 14 calendar days following receipt of the request for service.	UM 5
			7	One extension of up to 14 days may be allowed if either of the following conditions are met: a) The member or the provider requests an extension. b) The MCO justifies the need for additional information and how the extension is in the member's interest. c) Determinations must be made within the timeframe specified above (G3.6) and will be available to the Department upon request.	UM 5
			8	If the MCO meets the criteria above (G3.7) for extending the timeframe for standard service authorization decisions it must do both of the following: a) Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision. b) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	ME 7 MED 10
			9	The MCO must mail the notice within the following timeframes for expedited service authorization decisions, as expeditiously as the member's health condition requires	UM 5

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				and no later than 72 hours after receipt of the request for service.	
			10	Service authorization decisions not reached within the timeframes are considered an adverse benefit determination. In these situations, notice must be mailed no later than the date that the timeframes expire.	UM 5 MED 10
G4	Handling of Grievances and Appeals Medicaid: 42 C.F.R. § 438.406: Handling of grievances and appeals 2024-2025 BC+ and Medicaid SSI – DHS Contract	MCO requirements for handling of grievances and appeals, including acknowledgement, local committee composition and requirements, and special requirements for appeals.	1	In handling grievances and appeals, the MCO must give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	UM 3 MED 10
			2	The MCO's process for handling member grievances and appeals of adverse benefit determinations must acknowledge in writing receipt of each grievance and appeal within 10 business days. If being sent to a provider, written notices may be sent by mail or electronically via secure provider portal.	None
			3	The MCO's process for handling member grievances and appeals of adverse benefit determinations must ensure the individuals who make decisions on grievances and appeals are individuals: a) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. b) Who are health care professionals with appropriate clinical expertise, if deciding any of the following: An appeal of a denial that is based on lack of medical necessity; A grievance regarding denial of expedited	UM 8 UM 9 MED 10

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				resolution of an appeal; A grievance or appeal that involves clinical issues. c) Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.	
			4	The MCO's process for handling member grievances and appeals of adverse benefit determinations must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO must inform the member orally of the limited time available for this sufficiently in advance of the resolution time frame for appeals. If the member is presenting evidence in person, the MCO must inform the member in writing of the time and place of the meeting at least seven days before the meeting. In expedited appeals, the MCO must also notify the member orally.	UM 8
			5	The MCO's process for handling member grievances and appeals of adverse benefit determinations must provide the member and if applicable, the member's representative, the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO (or at the direction of the MCO) in connection with the appeal. This includes information or documentation generated by the MCO's providers, and subcontractors. The information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.	UM 8

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
			6	The MCO's process for handling member grievances and appeals of adverse benefit determinations must include as parties to the appeal, the member and the member's representative, or the legal representative of a deceased member's estate.	UM 7 UM 8
G5	Resolution and notification: Grievances and appeals Medicaid: 42 C.F.R. §438.408: Resolution and notification, Grievances and appeals 2024-2025 BC+ and Medicaid SSI – DHS Contract	Resolution and notification requirements for grievances and appeals.	1	Standard Resolution of Grievances: For standard resolution of a grievance a final written decision resolving the grievance within 30 calendar days of receiving the grievance (oral or written). This includes member grievances that were resolved during the initial phone call to the MCO.	None
			2	Standard Resolution of Appeals: For standard resolution of an appeal a final written decision resolving the appeal within 30 calendar days of receiving the appeal (oral or written).	UM 8 UM 9
			3	Expedited Resolution of Appeals: For expedited resolution of an appeal, the MCO must make reasonable effort to provide oral notice and issue a written disposition of an expedited hearing decision within 72 hours of receiving the verbal or written request for an expedited resolution.	UM 8 UM 9
			4	Grievances and Appeals Submitted by Individuals Purporting to be an Authorized Representative: If a grievance or appeal is submitted by an individual purporting to be the member's authorized representative and the MCO does not have the documented consent of the member for the individual to act as the member's representative on file, then the MCO must do the following:	None

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				a) Upon receipt of the grievance or appeal request, attempt to contact the member to confirm the member's desire for the grievance or appeal to proceed. b) If contact is made with the member and the member confirms, either verbally or in writing, that they desire the grievance or appeal to proceed, inform the member of the need to provide written consent for an individual to act as the member's authorized representative in the grievance or appeal and that, in the absence of such documented consent, the grievance or appeal will be processed as a request from the member. c) Initiate the appeal or grievance resolution process as of the date the member confirms that they wish to proceed with the appeal or grievance. d) Send the written acknowledgement letter to the member (and, if the member's documented consent is obtained prior to the acknowledgment letter being sent out, to the member's authorized representative) within the time frames. The MCO's receipt of the member's grievance or appeal with respect to these time frames is the date of the member's confirmation that they wish to proceed with the grievance or appeal.	
			5	The MCO may extend the time frames by up to 14 calendar days if any of the following occur: a) The member requests the extension. b) The MCO shows that there is need for additional information and how the delay is in the enrollee's interest. Documentation regarding this determination must be available to the Department upon request.	UM 9 MED 10

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				c) The total timeline for the MCO to finalize a formal grievance or appeal may not exceed 45 days from the date of the receipt.	
			6	If the MCO extends the time frames not at the request of the member, it must complete all of the following: a) Make reasonable efforts to give the member prompt oral notice of the delay. b) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. c) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	UM 8 UM 9 MED 10
			7	If the MCO fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the MCO's appeals process and the member may initiate a State fair hearing.	MED 10
			8	Grievance Resolutions: The MCO must provide written notice of resolution of a grievance in a format and language that, as a minimum, meet the standards described in the HMO and PIHP Communication, and Marketing Guide. Requirements include: a) Easily understood language and format. b) A fond size no smaller than 12 point. c) Available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of the member or potential member with disabilities or limited English proficiency.	MED 10

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				d) Large print (no smaller than 18-point) taglines and information on how to request auxiliary aids and services, including materials in alternative formats.	
			9	Appeals Resolutions: The MCO must provide written notice of resolution of an appeal in a format and language that, as a minimum, meet the standards described in the HMO and PIHP Communication, and Marketing Guide. Requirements include: a) Easily understood language and format. b) A font size no smaller than 12 point. c) Available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of the member or potential member with disabilities or limited English proficiency. d) Large print (no smaller than 18-point) taglines and information on how to request auxiliary aids and services, including materials in alternative formats.	ME 7 UM 8 UM 9 MED 10 MED 11
			10	Appeals: The MCO must issue a separate written notice of appeal resolution for each adverse benefit determination appealed by a member. For example, if two adverse benefit determinations are made by the MCO at the same time, the MCO must send out two separate adverse benefit determinations to the member. If the member appeals both adverse benefit determinations, the MCO must issue two separate notices of appeal resolution.	None
			11	The written notice of the resolution must include the results of the resolution process and the date it was completed. For appeals not resolved in the wholly in favor of the member the criteria below must be included.	ME 7 MED 10 MED 12

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				a) The right to request a fair hearing with the Division of Hearing and Appeals (DHA), and how to do so. b) The right to request and receive benefits while the hearing is pending, and how to make the request. c) That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's adverse benefit determination.	
			12	A member may request a State fair hearing with the DHA only after receiving notice that the MCO is upholding the adverse benefit determination. The member must request a State fair hearing no later than 90 calendar days from the date of receipt of the MCO's notice of resolution. Receipt of notice is presumed within five (5) calendar days of the date the notice was mailed.	None
			13	Upon request for information regarding a State fair hearing, the MCO must provide all relevant materials to appropriate party (the Department, the state's fiscal agent, or DHA) within five (5) business days, or sooner if possible. This includes: a) The MCO denial letter. b) All pertinent medical or dental records. c) Any other pertinent documentation, as determined by the Department.	None
G6	Expedited resolution of appeals Medicaid: 42 C.F.R. § 438.410:	Requirements for an expedited review process for appeals	1	The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the	UM 8 UM 9

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	Expedited resolution of appeals 2024-2025 BC+ and Medicaid SSI – DHS Contract			enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.	
			2	The MCO and its contracted providers must ensure that punitive action is not taken against anyone who requests an expedited resolution or supports a member's appeal, including but not limited to a member, authorized representative, or provider.	MED 10
			3	If the MCO denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution.	UM 8 MED 10
G7	Information about the grievance and appeal system to providers and subcontractors Medicaid: 42 C.F.R. § 438.414: Information about the grievance and appeal system to providers and subcontractor 2024-2025 BC+ and Medicaid SSI – DHS Contract		1	The MCO must distribute to its, providers and subcontractors the Ombuds Brochure on member grievance and appeal rights at the time the contract is entered. When a new Ombuds Brochure is available, the MCO must distribute copies to its providers or subcontractors within three weeks of receipt of the new brochure.	MED 10
			2	The MCO must ensure that its providers and subcontractors have written procedures for describing how members are informed of denied services. The MCO will make copies of the providers' and subcontractors' appeals and grievance procedures available for review upon the Department's request.	MED 10

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
G8	Recordkeeping requirements Medicaid: 42 C.F.R. § 438.416: Recordkeeping requirements 2024-2025 BC+ and Medicaid SSI – DHS Contract	Recordkeeping requirements for the MCO.	1	Records must distinguish BC+ or Medicaid SSI members from commercial members. If the MCO serves both BC+ and Medicaid SSI members, the records must distinguish between the two populations.	None
			2	The record of each grievance or appeal must contain, at a minimum, all of the following information: a) A general description of the reason for the grievance or appeal. b) The date received. c) The date of each review or, if applicable, review meeting. d) Resolution at each level of the appeal or grievance, if applicable. e) Date of resolution at each level, if applicable. f) Name of the covered person for whom the grievance or appeal was filed.	UM 9 MED 10
G9	Continuation of benefits while the MCP appeal and the state Fair Hearing are pending 42 C.F.R. § 438.420: Continuation of benefits while the MCO, PIHP, or PAHP appeal and the state fair	Requirements for continuation of benefits, duration, and member responsibility for costs.	1	Timely filing means the member has filed for continuation of benefits on or before the later of the following: a) Within 10 calendar days of the MCO sending the notice of adverse benefit determination. b) The intended effective date of the MCO's proposed adverse benefit determination.	MED 11
			2	The MCO must continue the member's benefits if all of the following occur: a) The enrollee files the request for an appeal timely per requirements. b) The appeal involves the termination, suspension, or reduction of previously authorized services. c) The services were ordered by an authorized provider.	MED 11

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	hearing are pending 2024-2025 BC+ and Medicaid SSI – DHS Contract			d) The period covered by the original authorization has not expired. e) The member or their authorized representative timely files for continuation of benefits.	
			3	If, at the member's request, the MCO continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of following occurs: a) The member withdraws the appeal or request for state fair hearing. b) The member fails to request a state fair hearing and continuation of benefits within 10 calendar days after the MCO sends the notice of an adverse resolution to the member's appeal. c) The DHA issues a hearing decision adverse to the member.	MED 11
			4	If the DHA upholds the MCO's adverse benefit determination, the MCO may pursue reimbursement from the member for the cost of services provided to the member while the MCO appeal and state fair hearing was pending, to the extent that they were provided solely because of the requirements of the contract article.	MED 11
G10	Effectuation of reversed appeal resolutions Medicaid: 42 C.F.R. § 438.424: Effectuation of reversed appeal resolution	Requirements for MCOs to reinstate benefits for reversed denials.	1	If the MCO or the DHA reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.	MED 10
			2	If the MCO or the DHA reverses a decision to deny authorization of services, and the member received the	MED 10

Grievance Systems Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	2024-2025 BC+ and Medicaid SSI – DHS Contract			disputed services while the appeal was pending, the MCO must pay for those services.	

Quality Assessment and Performance Improvement (QAPI) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
Q1	Quality Assessment and Performance Improvement: General rules Medicaid: 42 C.F.R. § 438.330(a): General rules 2024-2025 BC+ and Medicaid SSI – DHS Contract	The MCO's quality management program shall be administered through clear and appropriate structures, and include member, staff, and provider participation.	1	The MCO governing body is ultimately accountable to the Department for the quality of care provided to MCO members. Oversight responsibilities of the governing body include, at a minimum: a) Approval of the overall QAPI program b) An annual QAPI plan, designating an accountable entity or entities within the organization to provide oversight of QAPI c) Review of written reports from the designated entity on a periodic basis, which include a description of QAPI activities d) Progress on objectives, and improvements made e) Formal review on an annual basis of a written report on the QAPI program f) Directing modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the MCO	QI 1
			2	The MCO must designate a senior executive to be responsible for the operation and success of the QAPI program. If this individual is not the MCO Medical	QI 1

Quality Assessment and Performance Improvement (QAPI) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				Director, the Medical Director must have substantial involvement in the QAPI program. The designated individual shall be accountable for the QAPI activities of the MCO's own providers, as well as the MCO's subcontracted providers.	
			3	The QAPI committee must be in an organizational location within the MCO such that it can be responsible for all aspects of the QAPI program. The committee membership must be interdisciplinary and be made up of both providers and administrative staff of the MCO, including: a) A variety of health professions (for example, physical therapy, nursing, etc.) b) Qualified professionals specializing in mental health and substance abuse on a consulting basis c) Qualified professionals specializing in dental care on a consulting basis when an issue related to this area arises. d) A variety of medical disciplines (for example, medicine, surgery, radiology, etc.) e) An individual with specialized knowledge and experience with persons with disabilities f) MCO management or governing body	QI 1
			4	Members of the MCO must be able to contribute input to the QAPI Committee. The MCO must have a system to receive member input on quality improvement, document the input received, document the MCO's response to the input, including a description of any changes or studies it implemented as the result of the input and document feedback to members in response to input received. The MCO response must be timely.	None

Quality Assessment and Performance Improvement (QAPI) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
			5	The committee must meet on a regular basis, but not less frequently than quarterly.	None
			6	The activities of the QAPI Committee must be documented in the form of minutes and reports. The QAPI Committee must be accountable to the governing body.	QI 1
			7	QAPI activities of the MCO's providers and subcontractors, if separate from MCO QAPI activities, must be integrated into the overall MCO/QAPI program. Requirements to participate in QAPI activities, including submission of complete encounter data, are incorporated into all provider and subcontractor contracts and employment agreements.	QI 1 QI 2
			8	The MCO QAPI program shall provide feedback to the providers and subcontractors regarding the integration of, operation of, and corrective actions necessary in provider/subcontractor QAPI efforts.	QI 1 QI 2
			9	There is evidence that MCO management representative and providers participate in the development and implementation of the QAPI plan of the MCO. This provision shall not be construed to require that MCO management representatives and providers participate in every committee or subcommittee of the QAPI program.	QI 1
Q2	Basic elements of quality assessment and performance improvement program Medicaid: 42	The MCO shall maintain documentation and monitoring of the required activities of	1	The QAPI program must monitor and evaluate the quality of clinical care on an ongoing basis. Important aspects of care (i.e., acute, chronic conditions, high volume, high-risk preventive care and services) must be studied and prioritized for performance improvement and updating guidelines. Standardized quality indicators must be used to assess improvement, ensure	MED 7

Quality Assessment and Performance Improvement (QAPI) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	C.F.R. § 438.330(b): Basic elements of quality assessment and performance improvement programs 2024-2025 BC+ and Medicaid SSI – DHS Contract	the Quality Management program		achievement of minimum performance levels, monitor adherence to guidelines, and identify patterns of over and underutilization.	
			2	The MCO must use appropriate clinicians to evaluate clinical data and serve on multi-disciplinary teams tasked with analyzing and addressing data issues.	None
			3	The MCO must also monitor and evaluate care and services in certain priority clinical and non-clinical areas. Non-clinical areas of monitoring and evaluation must include member satisfaction.	None
			4	The MCO and its subcontractors must have documented policies and procedures for all UM activities that involve determining medical necessity and processing requests for initial and continuing authorization of services (42 C.F.R. § 438.210(b)(1)).	UM 2 MED 7
			5	The MCO must communicate to providers the criteria used to determine medical necessity and appropriateness. The criteria for determining medical necessity may not be more stringent than what is used in the State Medicaid program, as set forth in Wis. Adm. Code § DHS 101.03(96m), including any quantitative and nonquantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other published State policy and procedures. Documentation of denial of services must be available to the Department upon request.	UM 2 MED 7
			6	When reviewing requests for authorization of services, qualified medical professionals must be involved in any decision-making that requires clinical judgment. The decision to deny, reduce or authorize a service that is	UM 2 MED 7

Quality Assessment and Performance Improvement (QAPI) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
				less than requested must be made by a health professional with appropriate clinical expertise in treating the affected member's condition(s).	
			7	If the MCO delegates any part of the UM program to a third party, the delegation must meet the requirements in this Contract.	UM 13
Q3	Performance measurement Medicaid: 42 C.F.R. § 438.330(c): Performance measurement 2024-2025 BC+ and Medicaid SSI – DHS Contract	Performance Measurement Validation	N/A	The Performance Measurement Validation occurs separate from the Compliance with Standards review.	N/A
Q4	Performance improvement projects Medicaid: 42 C.F.R. § 438.330(d) 2024-2025 BC+ and Medicaid SSI – DHS Contract	Performance Improvement Project Validation	N/A	The Performance Improvement Project Validation occurs separate from the Compliance with Standards review.	N/A
Q5	QAPI evaluations review		1	The MCO must evaluate the overall effectiveness of its QAPI program annually to determine whether the program has demonstrated improvement, where needed,	QI 1

Quality Assessment and Performance Improvement (QAPI) Standards					
Standard	**Citation**	**Standard Description**	**Scoring Element**	**State Requirements/Scoring Elements**	**NCQA Accreditation Standard**
	Medicaid: 42 C.F.R. § 438.330(e)(2): Program and review by the state 2024-2025 BC+ and Medicaid SSI – DHS Contract	The MCO creates and evaluates the quality work plan annually.		in the quality of care and service provided to its BC+ and Medicaid SSI population.	
			2	New goals and objectives must be set at least annually based on findings from quality improvement activities and studies and results from member satisfaction surveys and performance measures.	QI 1
			3	The QAPI work plan must include Annual plan to meet its Pay-for-Performance (P4P) goals and submit NCQA audited P4P results to the Department on time.	None
			4	The QAPI work plan must include Annual Performance Improvement Projects (PIPs) topic selection, implementation, monitoring, and final report submission to the DHS and to DHS' EQRO.	None