WISCONSIN DEPARTMENT *of* HEALTH SERVICES

2021 MEDICAID MANAGED CARE QUALITY STRATEGY

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STATE OF WISCONSIN

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Contents

Executive Summary

The Wisconsin Department of Health Services (DHS) Division of Medicaid Services (DMS) has broad quality goals that include improving access, member choice, and health equity; promoting appropriate, efficient, and effective care; focusing on patient or person-centered care and superior clinical and personal outcomes; and employing principles of evidence-based continuous quality improvement. These goals, as well as the objectives, strategies, programs, specific interventions, activities intended to achieve the goals, and the process for monitoring progress toward these goals, are described in the Wisconsin Medicaid Managed Care Quality Strategy document (Quality Strategy). Definitions for commonly used terms in the Wisconsin Medicaid Managed Care Quality Strategy can be found in the Glossary in Section 8.

The Quality Strategy was prepared by DMS in accordance with requirements from the Centers for Medicare & Medicaid Services (CMS) for states to develop a strategy to assess and improve the quality of managed care services offered to Medicaid beneficiaries. It complies with the federal Medicaid managed care rule, 42 C.F.R. § 438.340 requirements.

In Wisconsin, acute care services for managed care members are furnished by BadgerCare Plus and Supplemental Security Income (SSI) health maintenance organizations (HMOs). Additionally, there are three managed care prepaid inpatient health plans (PIHPs) providing acute care services to youth with special needs through the Children Come First, Wraparound Milwaukee, and Care4Kids programs. Long-term care services for managed care members are furnished by Family Care and Family Care Partnership long-term care managed care organizations (MCOs), which are also known as prepaid inpatient health plans (PIHPs). Family Care Partnership MCOs are also capitated to administer acute care services. For the purposes of this Quality Strategy, the term PIHPs is used to refer to both MCOs and the Children Come First, Wraparound Milwaukee, and Care4Kids programs. Although there is alignment and substantial overlap between acute care and long-term care goals, objectives, and strategies, some divergence is necessary to address the specific needs of the members served by each program. This document reflects these similarities and differences and is organized to demonstrate the relationship between goals, objectives, strategies, programs, activities, and interventions for both acute care and long-term care.

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

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

Delivery system and person-centered care: Delivery system strategies focus on the way HMOs, PIHPs, and providers care for patients. These strategies emphasize care management and coordination, use of health homes and medical homes for specific conditions and populations, and continual attention to the health and safety of Medicaid members. Person-centered care

strategies focus on building partnerships between members and their care teams and emphasize high-quality, evidence-based, accessible care in which individual needs, preferences, and values of members and caretakers are paramount.

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

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

1. Introduction

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

a. Purpose

This document meets the federal requirements of 42 C.F.R. § 438.340 to describe the strategies for assessment and quality improvement of managed care services offered to Medicaid beneficiaries. It includes the specific strategies Wisconsin will use to align programs to best meet the health care needs of Medicaid members and continually improve health for Wisconsin residents. This Quality Strategy sets a three-year vision for DMS to achieve its quality goals and objectives, and it is intended to evolve over time.

b. Scope

DMS has a broad view of quality that includes improving access, member choice, and health equity; promoting appropriate, efficient, and effective care; focusing on patient-centered care and superior clinical outcomes; and employing principles of evidence-based continuous quality improvement. Acute care services for managed care members are furnished by BadgerCare Plus and Supplemental Security Income (SSI) health maintenance organizations (HMOs). DMS has dedicated acute care teams that manage the BadgerCare Plus and SSI HMOs. Additional acute managed care programs include those prepaid inpatient health plans (PHIPs) serving youth with special needs enrolled in Children Come First, Wraparound Milwaukee, and Care4Kids. Long-term care services for managed care members (e.g., managed long-term care services and supports) are furnished by Family Care and Family Care Partnership long-term care managed care organizations (MCOs), also referred to as pre-paid inpatient health plans (PIHPs). The Family Care Partnership program also covers acute and primary care services. DMS also has dedicated long-term care teams that manage the long-term care PIHPs. Although there is alignment and substantial overlap between acute care and long-term care program goals, objectives, and strategies, some divergence is necessary to address the specific needs of the members served by each program. This document is organized to reflect these similarities and differences.

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

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

FIGURE 1

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

c. History of Medicaid in Wisconsin

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

In 1999, Wisconsin added BadgerCare to provide Medicaid acute, primary, and behavioral services to parents and children. Then in 2008, under a federal demonstration waiver, BadgerCare merged Medicaid with Children's Health Insurance Program to create BadgerCare Plus. From 2009 through 2013, eligibility was extended to childless adults with income up to 200% of the federal poverty level with a capped enrollment. In 2014, eligibility was amended to include parents, caregivers, and childless adults with income up to 100% of the federal poverty level, covering all adults living in poverty for the first time. Wisconsin also received federal

approval in 2014 to operate a medical home, Care4Kids, to provide benefits to foster children through a non-risk prepaid inpatient health plan. Currently, most BadgerCare Plus beneficiaries and SSI adults are required to enroll in a managed care plan. In 2018, adults with SSI coverage who were not eligible for waiver or nursing-home level services and not dually-covered by Medicare were enrolled in SSI HMOs, which significantly increased managed care program size. Wisconsin has statewide coverage for BadgerCare Plus and Medicaid SSI programs, with multiple HMOs for members to choose from in each county.

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

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

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

In 2006, the Wisconsin Legislature's Joint Committee on Finance approved Family Care to move out of its pilot phase and begin expansion in 2007. In July 2018, Family Care expanded statewide. As of March 2021, the Family Care programs reached full entitlement. Family Care will continue to provide all Medicaid-covered long-term care services and supports to people who qualify for or are at risk of an institutional level of care. Family Care and Family Care Partnership will continue to work to keep members in their homes or in the least restrictive setting for as long as possible.

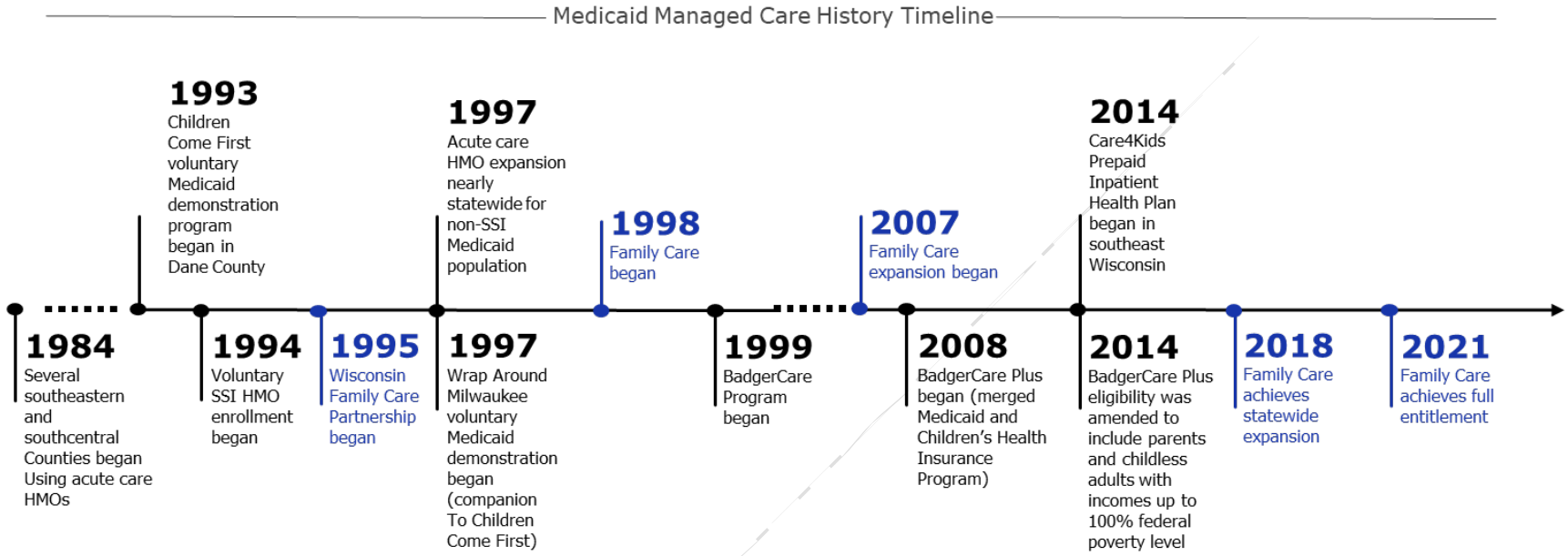
Medicaid Managed Care History Timeline
1984
Several southeastern and southcentral Counties began Using acute care HMOs
1993
Children Come First voluntary Medicaid demonstration program began in Dane County
1994
Voluntary SSI HMO enrollment began
1995
Wisconsin Family Care Partnership began
1997
Acute care HMO expansion nearly statewide for non-SSI Medicaid population
1997
Wrap Around Milwaukee voluntary Medicaid demonstration began (companion To Children Come First)
1998
Family Care began
1999
BadgerCare Program began
2007
Family Care expansion began
2008
BadgerCare Plus began (merged Medicaid and Children's Health Insurance Program)
2014
Care4Kids Prepaid Inpatient Health Plan began in southeast Wisconsin
2014
BadgerCare Plus eligibility was amended to include parents and childless adults with incomes up to 100% federal poverty level
2018
Family Care achieves statewide expansion
2021
Family Care achieves full entitlement

FIGURE 2

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

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

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

The draft Quality Strategy document was made available April 22 through May 21, 2021 for comment by stakeholders and the public through a number of outreach efforts. These outreach efforts include presentation to advisory committees and councils, presentation to the Medical Care Advisory Committee, tribal consultation, publication on the DHS website, newspaper announcement, and GovD notice. Following the 30-day public comment period, all feedback was reviewed and included in the final Quality Strategy publication. Appendix 8e presents the comments received on the Quality Strategy. Meeting minutes from the Medical Care Advisory Committee presentation and discussion on the Quality Strategy can be found here. The final version of the Quality Strategy is available on the DHS website.

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

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

3. Organizational Goals, Objectives, and Foundational Principles

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

a. DHS Mission, Vision, and Values

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

Vision: Everyone living their best life.

Values:

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

b. DMS Mission, Vision, Values

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

Vision: People empowered to realize their full potential.

Values:

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

c. Foundational Principles

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

- **Whole person:** Focus on the whole person, including their physical, psychosocial, and spiritual needs to live and work freely in their home and community and to improve well-being.
- **Evaluate and address health disparities:** Consider the impact on health disparities when developing, implementing, and managing all programs and initiatives. This will include addressing social determinants of health and supporting access to community services and supports.
- **Access:** Empower people with access to an array of services and supports. Ensuring member access to care drives decision-making in our program management.
- **Choice:** Engage people to make meaningful choices about where and with whom they live, and their services and who provides them. Consider member preferences, health and social needs, person-centered care, and member engagement when making decisions about DMS programs and initiatives.
- **Use data to evaluate programs and inform decision making:** Use data to evaluate and make timely decisions about policies, strategies, programs, and infrastructure needs.
- **High quality:** Ensure continuous improvement of high-quality programs to achieve members' identified goals and outcomes.
- **Collaboration:** Foster collaborative relationships through robust and transparent communication.
- **Cost–Effective - be good stewards of Medicaid funds:** Promote efficient and cost-effective services and supports through innovation, standards, data-driven quality, and evidence-based

practices. Maximize the value of each dollar spent, as reflected by cost-effectiveness, accountability for the management of contracts, and quality of services provided to Medicaid members.

- **Leadership:** Lead the nation in developing innovative approaches for improving the delivery of acute and long-term care services and supports.
- **Engage:** Provide a workplace with opportunities for staff engagement and personal and professional growth.

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

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

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

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

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

presented to give context to how state results compare to national results. In the Long-Term Care Quality Measures Baseline Data table (Table 4), the NCI National Average result is presented as a comparison with the state result for each measure. These data provide a sense for how Wisconsin performs in relation to national performance on the same measures.

TABLE 1. ACUTE AND PRIMARY CARE GOALS AND OBJECTIVES

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

	• 2017: 33.0% • 2018: 39.0% • 2019: 40.5%	
Maternal and Perinatal Health		
Goal 2: Set the stage for healthy birth outcomes and long-term well-being of mothers and infants.	**Improve outcomes on the following measures:** **Objective 2a:** Prenatal and Postpartum Care: Timeliness of Prenatal Care • 2017: 80.6% • 2018: 84.0% • 2019: 89.2% **Objective 2b:** Prenatal and Postpartum Care: Postpartum Care • 2017: 67.3% • 2018: 65.5% • 2019: 76.5%	**Data Source:** CMS Child Core Set CMS Adult Core Set NCQA HEDIS Measures Objective 2a. PPC-CH Objective 2b. PPC-AD
Care of Acute and Chronic Conditions		
Goal 3: Provide support to manage chronic conditions and reduce adverse acute outcomes.	**Improve outcomes on the following measure:** **Objective 3:** Controlling High Blood Pressure • 2017: 56.9% • 2018: 64.7% • 2019: 64.3%	**Data Source:** CMS Adult Core Set NCQA HEDIS Measure Objective 3. CBP-AD
Behavioral Health Care		
Goal 4: Promote early intervention for substance use and timely follow-up care for behavioral health concerns.	**Improve outcomes on the following measures:** **Objective 4a.** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Engagement)	**Data Source:** CMS Adult Core Set NCQA HEDIS Measures Objective 4a. IET-AD (Engagement) Objective 4b. FUA-30* Objective 4c. FUM-30*

	• 2017: 9.4% • 2018: 10.0% • 2019: 11.7% **Objective 4b.** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 Days) • 2017: 15.5% • 2018: 16.8% • 2019: 16.0% **Objective 4c.** Follow-Up After Emergency Department Visit for Mental Illness (30 Days) • 2017: 42.2% • 2018: 55.7% • 2019: 60.6% **Objective 4d.** Follow-Up After Hospitalization for Mental Illness (30 Days) • 2017: 54.9% • 2018: 54.9% • 2019: 58.9%	Objective 4d. FUH-30 *2017 rates for FUA-30 and FUM-30 are limited to reporting by 14 of 19 HMOs.

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

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

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

Process and Outcome measures - e.g., from HbA1c testing to HbA1c Control, related to diabetes care.

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

TABLE 2. ACUTE AND PRIMARY CARE QUALITY MEASURES BASELINE DATA

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

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

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

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

TABLE 3. LONG-TERM CARE GOALS AND OBJECTIVES

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

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

	Increase the percentage of people who work in non-workshop settings. • 2016: 22.3% I/DD* / 3.4% PD** • 2017: 21.9% I/DD / 3.3% PD • 2018: 22.1% I/DD / 3.3% PD **Objective 5c.** Increase the percentage of people who are active in their community • 2016-2017: 32% IPS • 2017-2018: 38% IPS / 47% AD • 2018-2019**:** 33% IPS / 46% AD *I/DD: Intellectual and/or Developmental Disability **PD: Physical Disability	Wisconsin Long-Term Care Scorecard Report: 2015-2017 • Indicator 3.1.2 (I/DD) • Indicator 3.1.3 (PD) **Data Source 5c:** National Core Indicators: In-Person Survey (IPS) • NCI-66 National Core Indicators: Aging and Disabilities (AD) Survey • NCI-AD-1
Caregiver Support and Workforce		
Goal 6: Caregiver Support Offer financial, emotional, and technical support for family caregivers or natural supports of individuals who use HCBS.	**Objective 6.** Increase the percentage of adults living with spouse and/or family receiving unpaid care who also receive respite. • 2016: 12.9% • 2017: 12.2% • 2018: 12.1%	**Data Source:** Wisconsin Long-Term Care Scorecard Report: 2015-2017 • Indicator 4.2
Goal 7: System Performance and Accountability Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.	**Objective 7a.** Increase the percentage of total Long-Term Services and Supports (LTSS) Medicaid funding spent on the care and support of adult enrollees in a Home and Community Based Services (HCBS) waiver • 2016: 75.0% • 2017: 76.9% • 2018: 78.9%	**Data Source 7a:** Wisconsin Long-Term Care Scorecard Report: 2015-2017 • Indicator 1.2 **Data Source 7b:** Wisconsin Long-Term Care Scorecard Report: 2015-2017 • Indicator 2.1

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

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

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

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

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

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

TABLE 4. LONG-TERM CARE QUALITY MEASURES BASELINE DATA

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

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

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

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

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

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

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

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

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

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

4. DMS Quality Strategies: § 438.340(b)

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

a. Payment Strategies

Payment strategies allow DMS to uphold the foundational principle of cost-effectiveness and are utilized to direct focus on key objectives. The following strategies identify existing and planned initiatives; in addition, DMS will develop any additional funding mechanisms, methodologies, or programmatic changes necessary to comply with directives from the legislature or governor.

i. Enhance Value-Based Purchasing

BadgerCare Plus and SSI HMOs have specific and increasingly advanced quality measure reporting requirements required of the pay-for-performance initiative. This strategy puts financial incentives and withholds on BadgerCare Plus and SSI HMOs to help achieve quality goals. It also uses public reporting on pay-for-performance measures through report cards as a way to drive provider quality improvement and support other strategies, such as member engagement and activation. Beginning in 2020 and expanding in 2021 is the use of HMO Performance Improvement Projects (PIPs) focused on reducing health disparities and increasing cultural competence and screening for drivers of health as part of the HMO P4P withhold. This recent expansion of P4P provides financial incentive for HMOs and partner clinics to specifically target identified health disparities in their quality improvement projects.

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

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

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

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

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

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

ii. Reduce Avoidable, Non-Value Added Care

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

The acute care program areas will focus on reducing potentially preventable readmissions by working directly with hospitals that receive fee-for-service payments to serve Wisconsin Medicaid members, and by working with BadgerCare Plus and Medicaid SSI HMOs that serve members through managed care. This strategy is expected to promote appropriate access to care (i.e., primary care or urgent care rather than emergency room, when appropriate).

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

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

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

b. Delivery System and Person-Centered Care Strategies

Delivery system strategies focus on the way HMOs, PIHPs, and providers care for members. Person-centered care strategies focus on building partnerships between members and their care teams around high quality, evidence-based, accessible care in which individual needs, preferences, and values of members and caretakers are paramount.[5] These strategies support DMS goals and objectives related to improving access to appropriate care, improving health outcomes, and reducing disparities. Implementation of delivery system and person-centered care strategies will continue to help transform how acute care and/or long-term care services are:

- Accessed and utilized by members, and will engage members in self-management of their health and care needs.
- Delivered to members by HMOs, PIHPs, and providers.

[5] IBID

- Reimbursed, moving away from traditional fee-for-service and pay-for-volume arrangements.
- Enabled through use of health care data and information technology.
- Monitored to hold HMOs, PIHPs, and providers accountable for improving the quality of care, responding appropriately to incidents when they occur, and improving the member experience.

i. Enhance Care Coordination and Person-Centered Care

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

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

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

ii. Improve Health Homes

To improve health outcomes, better engage members, and improve the member experience of care, DMS will continue to require BadgerCare Plus and SSI HMOs to improve, manage, and coordinate care for specific populations using health homes. Health homes are comprehensive care models focused on providing high-value, member-centric, coordinated care for members with specific chronic health conditions and risk factors.[6] A medical home model, with a similar concept of coordinated care, currently offers prenatal and postpartum care for high-risk pregnant BadgerCare Plus and SSI HMOs members. In this Quality Strategy period, the existing medical

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

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

iii. Ensure Health and Safety

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

DMS also requires long-term care PIHPs to engage in the discovery, investigation, remediation, and prevention of incidents that may compromise the health and safety of Family Care and Family Care Partnership members.

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

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

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

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

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

c. Member Engagement and Choice Strategies

DMS promotes member and family engagement by ensuring they are partners in defining, designing, participating in, and assessing the care practices and systems that serve them to make

sure these practices and systems are respectful of and responsive to individual member preferences, needs, and values. This collaborative engagement allows member values to guide all clinical decisions and drives genuine transformation in provider attitudes, behavior, and practice.[7] These strategies for connecting members with their health coverage and care are essential for achieving quality goals and objectives. DMS has goals and objectives related to improving engagement of members in their care and experience of care, as well as focusing on empowering members to make meaningful choices about their care, supports, and services.

i. Promote Member Engagement

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

- Understand their benefits and available services.
- Actively choose their HMOs and establish care with their selected or assigned primary care provider.
- Stay with their chosen pharmacies and providers, which will help strengthen relationships between the members and providers.
- Proactively receive health screenings, preventive care, and immunizations, as appropriate.
- Work with their HMO to complete a health needs assessment and a care plan, if needed to address their health needs.
- Use online health portals available from HMOs and providers to access their health information.

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

Recognizing the cultural diversity of Medicaid members, DMS will also encourage HMOs to become more culturally competent through self-assessments and training staff and providers. This includes requiring BadgerCare Plus and SSI HMOs to conduct a culturally and linguistically appropriate services (CLAS)[8] standards self-assessment and to provide information to DMS on how these standards are being integrated into their policies and procedures.

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

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

ii. Long-Term Care Choice Strategy

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

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

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

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

Finally, the long-term care choice strategy includes ensuring members can pursue competitive integrated employment, which involves a person-centered planning process and includes a variety of experiences that build toward successful employment. Through the development of guiding principles for competitive integrated employment[10], an employment best practice guide, and statewide benchmarks, Wisconsin strives to be a leader in providing services and supports that result in competitive integrated employment for individuals who wish to work.

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

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

5. Enabling Infrastructure: Data and Technology

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

Timely access to complete and accurate health data for DMS, providers, HMOs, and PIHPs is essential for the execution of payment and service delivery strategies. DMS acute care and long-term care program areas share many enabling technologies, such as the integrated eligibility determination system known as CARES and the MMIS. Each BadgerCare Plus HMO, SSI HMO, and long-term care PIHP also has their own enabling technologies for quality monitoring and improvement, including care management software and information systems. For a more detailed list of current enabling data and technology, please see Appendix 8d.

DMS is improving statewide health information exchange by requiring all BadgerCare Plus and SSI HMOs to participate in WISHIN (Wisconsin Statewide Health Information Network) by June 2021. Additionally, all SSI HMOs are required to incorporate member care plan information into WISHIN in 2021. These contractual requirements will allow the connection of member's health information (including care plans for SSI members) among physicians, clinics, hospitals, pharmacies, and clinical laboratories across the state of Wisconsin. Adopting such health information exchange leads to faster and better clinical decisions, less duplication, more effective transitions of care, and reduced administrative costs.

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

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

a. Accelerate Quality Monitoring

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

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

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

- Monitoring and identifying health disparities by collecting and using appropriate member eligibility, enrollment, assessment, and care utilization data.
- Assessing and stratifying long-term care member needs through tools such as the Functional Screen.
- Supporting member engagement by providing an easily accessible public website for quality measures reporting and external quality review organization and program evaluation findings, in compliance with the managed care rule.

b. Use Technology to Engage Members

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

6. DMS Managed Care Programs

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

a. Acute Care Programs

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

i. BadgerCare Plus HMOs

Program Description	In 1999, Wisconsin introduced BadgerCare to provide acute, primary, and behavioral health Medicaid services to parents and children. Then in 2008, under a federal demonstration waiver, BadgerCare merged Medicaid (Title XIX of the Social Security Act) with the Children's Health Insurance Program (Title XXI of the Social Security Act) to become BadgerCare Plus. Through BadgerCare Plus, from 2009 through 2013, the state of Wisconsin extended eligibility to childless adults with income up to 200% of the federal poverty level at a capped enrollment. In 2014, eligibility was amended to include parents and caregivers and childless adults with income up to 100% of the federal poverty level.

	Eligible BadgerCare Plus members are required to enroll in managed care since there are at least two or more HMOs covering every county in the state. Currently, there are 14 HMOs serving BadgerCare Plus members. Any HMO that meets state network adequacy requirements and additional qualifications can contract to provide services with Wisconsin Medicaid. Rates are actuarially sound and set annually by DMS and its actuaries. HMOs are required to participate in the pay-for-performance program, core reporting, and other reporting. Further quality assurance requirements are outlined in Section 6.
Activities and Interventions	Payment strategy: • Pay-for-performance and core reporting, including health disparities performance improvement projects • Potentially preventable readmissions Delivery system and person-centered care strategy: • Performance improvement projects • Care Plans Member engagement and choice strategy: • Consumer Assessment of Healthcare Providers and Systems satisfaction survey for children • Public reporting, including website and report cards • Prevalent language rules
Next Steps	DMS will continue focusing on implementing the payment reform strategy in BadgerCare Plus HMOs, through pay-for-performance and reducing potentially preventable readmission rates. The BadgerCare Plus HMO program will also increase member engagement initiatives as a strategy to achieve objectives related to member engagement and experience of care. In 2021, BadgerCare Plus HMOs will continue with their post-partum care disparities performance improvement projects, which will be subject to an increase of the withhold to 1.5%. BadgerCare Plus HMOs and a partner clinic for each will document the current state of screening their members on drivers of health as part of their performance improvement projects in addressing health disparities. Moreover, in 2021, DMS finalized policy to require that by end of 2023, all HMOs obtain a NCQA accreditation for their Medicaid line of business and obtain the NCQA Multicultural Health Care Distinction (MHCD). NCQA Accreditation will streamline regulatory compliance reviews for health plans and help to improve health plan performance on CAHPS and HEDIS measures. The MHCD will allow for consistent review of the National Culturally and Linguistically Appropriate Services (CLAS)

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

ii. SSI HMOs

Program Description	In 1994, Wisconsin Medicaid created the SSI managed care program for individuals deemed disabled and eligible for supplemental security income. Originally, SSI managed care started in Milwaukee County where eligible members could enroll in HMOs voluntarily. In 2004, Wisconsin Medicaid contracted with more HMOs to expand SSI managed care into the remainder of the state. In 2018, enrollment in HMOs became mandatory for SSI adult members who live in counties where there are two or more HMOs serving SSI members. Medicaid SSI members who have dual eligibility for Medicaid and Medicare and members who are enrolled in a certain waivers or other programs are not eligible for mandatory enrollment. There are currently eight HMOs serving Wisconsin's elderly, blind, or disabled Medicaid and SSI Medicaid members. Any SSI HMO meeting the network adequacy requirements and additional qualifications can contract with Wisconsin Medicaid to provide services to SSI members. Rates are actuarially sound and set annually by DMS and its actuaries. HMOs are required to participate in pay-for-performance, core reporting, and other reporting. Further quality assurance requirements are outlined in the Quality Assurance Section.
Activities and Interventions	Payment strategy: • Pay-for-performance and core reporting • Potentially preventable readmissions Delivery system and person-centered care strategies: • Performance improvement projects • Care management initiative – needs assessment and stratification, timely and comprehensive care plan, transitional care processes, and enhanced care coordination, including a Wisconsin interdisciplinary care team structure for members with highest needs Member engagement and choice strategy: • Public reporting, including website and report cards • Prevalent language rules

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

iii. Care4Kids Medical Home

Program Description	DHS and the Department of Children and Families partnered to implement Care4Kids, a program offering comprehensive and coordinated health services for children and youth in foster care through a prepaid inpatient health plan. Care4Kids is funded through a non-risk monthly payment with an administrative fee for care coordination (assessment and coordination) and physical and behavioral health services, which are reconciled annually to the fee-for-service costs of services provided. Care4Kids launched on January 1, 2014, in six southeastern Wisconsin counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha. Care4Kids gives parents/guardians a choice to enroll their child in a fully coordinated Medicaid medical care system or to have them receive Medicaid fee-for-service benefits. Parents/guardians may enroll or un-enroll their child at any time. The program is designed to ensure that children in foster care receive high-quality, trauma-informed care based on a child-centric, individualized treatment plan, which includes early screening and a comprehensive health assessment at the time of entry into foster care, an enhanced schedule of well

	child checks, and access to dental and evidence-informed behavioral health services. Expected outcomes include: • Improved physical and mental health • Improved resiliency • Shorter stays in out-of-home care. These positive outcomes are also expected to result in long-term savings in publicly funded programs.
Activities and Interventions	Delivery system and person-centered care strategy: • Timely access to a full range of developmentally appropriate services • Screening and comprehensive initial health assessment • Comprehensive care plan • Transition health care plan • Care coordination
Next Steps	Care4Kids will focus on enhancing the development of its care model and defining and implementing additional quality measures. This will further develop the program as a center of excellence in providing coordinated care for children and youth in foster care in southeastern Wisconsin, thereby implementing the delivery system reform strategy. DMS will work with Care4Kids and the external quality review organization to ensure Care4Kids achieve compliance with requirements of the care management model. In 2021, DMS will continue requiring implementation of a performance improvement project. More information regarding specific performance improvement projects requirements are outlined in the Care4Kids contract and quality guide. Both the contract and quality guide are evaluated annually and updated as needed to incorporate updates in initiatives, measures, and strategies.

iv. Children Come First / Wraparound Milwaukee

Program Description	Children Come First and Wraparound Milwaukee are two county-based prepaid inpatient health plans that offer multi-agency, community-based mental health and alcohol and other drug abuse services under one umbrella for BadgerCare Plus and SSI youth with severe emotional disturbances. Eligible youth are enrolled in the programs through referral or court order. The programs seek to keep youth with severe emotional disturbances out of institutions and reallocate resources previously used for institutionalization to community-based wraparound services for youth with severe emotional disturbances.

	DMS funds Children Come First and Wraparound Milwaukee through a capitation rate for care coordination and behavioral health services, and members get their physical health care through fee-for-service.
Activities and Interventions	Delivery system and person-centered care strategy: • Care coordination • Child and family treatment team • Assessment of strengths and needs • Individualized service and support plan of care • Crisis plan
Next Steps	Children Come First and Wraparound Milwaukee will continue to implement the delivery system reform strategy to achieve improved access to behavioral health care. The program will work to ensure compliance with the Medicaid managed care rule, including submission of encounter data following national standards. Each county program has performed significant efforts to adopt and align the federal managed care rule requirements within their program infrastructure and operations over the past two years, which DMS and the EQRO will continue to monitor and evaluate through ongoing operations. DMS will work with Children Come First and Wraparound Milwaukee and the external quality review organization to ensure the programs achieve compliance with requirements of the care management model. In 2021, DMS will continue requiring implementation of a performance improvement project. More information regarding specific performance improvement projects requirements are outlined in the Children Come First and Wraparound Milwaukee contracts.

v. HIV/AIDS Health Home

Program Description	The HIV/AIDS Health Home targets individuals with HIV and at least one other diagnosed chronic condition or who are at risk of developing another chronic condition. Vivent Health is the sole AIDS service organization in Wisconsin. It has locations in Milwaukee, Kenosha, Brown, and Dane counties. In the HIV/AIDS Health Home, Vivent Health provides comprehensive care coordination for eligible individuals across all health care settings and between health and community care settings. Vivent Health has a core team of health care professionals that includes experts in the care and treatment of individuals diagnosed with HIV infection. From 2012-2016, members had to be enrolled in fee-for-service. Effective January 1, 2016, the HIV/AIDS Health Home care coordination benefit was expanded to include individuals participating in home and community-based

	services (1915[c])[11] waiver program, as well as members in BadgerCare Plus and SSI HMOs. The HIV/AIDS Health Home is funded through a per-member-per-month care management fee and annual flat fee.
Activities and Interventions	Delivery system and person-centered care strategy: • Comprehensive care management • Care coordination • Comprehensive transitional care • Member and family support • Referral to community and social support services • Screening, Brief Intervention, and Referral to Treatment (SBIRT)
Next Steps	The HIV/AIDS Health Home will continue to implement the delivery system reform strategy by focusing on quality improvement, which will include requiring collection of data and quality measures to set baselines and provide measures for program performance, and coordination of record reviews by DMS and the DHS Division of Public Health.

vi. Obstetrics Medical Home

Program Description	The Obstetrics Medical Home launched in January 2011 as a pilot limited to six southeast Wisconsin counties (Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha). In 2014, the program expanded to Dane and Rock counties and became available to SSI members. There is currently a combined total of 12 BadgerCare Plus and SSI HMOs participating in the Obstetrics Medical Home program. The program's objective is to improve birth outcomes and reduce birth disparities among high-risk pregnant women enrolled in BadgerCare Plus and SSI HMOs by providing enhanced care coordination services. The Obstetrics Medical Home services and care coordination interventions are delivered by clinics that are paid by the BadgerCare Plus and SSI HMOs. DMS monitors clinic and HMO performance and outcomes through external quality review organization reviews and annual reports from the clinics and HMOs. There is an enhanced, $1,000 per member payment to clinics for meeting program criteria and an additional $1,000 per member payment tied to positive birth outcomes (birthweight is at or over 2,500 grams and gestational age is at or over 37 weeks).

[11]Home and Community-Based Services 1915 (c). Medicaid.gov. Accessed at: https://www.medicaid.gov/medicaid/hcbs/authorities/1915-c/index.html. December 4, 2017.

Activities and Interventions	Delivery system and person-centered care strategy: • Patient engagement and assessment to identify needs • Patient education • Care coordination • Complex care management • Care plan • Discharge planning • Coordination with prenatal care coordination (PNCC) benefit Member engagement and choice: home visits
Next Steps	The Obstetrics Medical Home (OBMH) will continue employing administrative efficiencies and focus on quality improvement to continue implementing the delivery system reform strategy and achieve the objective of improving birth outcomes and reducing birth disparities. Given Wisconsin's disparate racial birth outcomes, this initiative focuses on delivering culturally and linguistically appropriate services to optimize outcomes and close disparity gaps, especially among its Black/African American member population. During this Quality Strategy period, DMS plans to evaluate this model of care and look for improvement opportunities for coming years.

b. Long-Term Care Programs

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

i. Family Care

Program Description	Family Care, a national model in long-term care, was established in 1998. Currently, DHS contracts with four PIHPs to operate Family Care in 72 counties throughout Wisconsin. Family Care PIHPs provide or coordinate cost-effective and flexible services tailored to each member's needs. DMS provides each Family Care PIHP with a monthly payment for each member and the PIHP uses these funds to provide and coordinate services for all of its members. Each Family Care member is the essential member of his or her own interdisciplinary care team. The team works directly with the member to identify the member's needs, strengths, preferences, and available resources in order to develop a person-centered plan. The person-centered plan may include help from natural supports (for example: family, friends, neighbors). When a member does not have natural supports available, the Family Care PIHP will purchase the necessary services for the member.
Activities and Interventions	Payment strategy: pay-for-performance Delivery system and person-centered care strategy: • Performance improvement projects

	• Member-centered care plan • Care management reviews • Independent file review Member engagement and choice strategy: • Member satisfaction survey • Adult long-term care functional screen • PIHP Member Advisory Committee
Next Steps	The Family Care program will continue to focus on quality improvement, including continuing and developing new pay-for-performance initiatives; keeping members healthy, safe, and supported in the community for as long as possible; providing increased support for behavioral health; and supporting competitive integrated employment. These activities and interventions, which are and will continue to be implemented in Family Care, are also discussed in the DMS Quality Strategies Section.

ii. Family Care Partnership

Current Program Design	In 1995, Wisconsin began redesigning the long term care system for older adults and adults with disabilities who qualify for institutional levels of care, including individuals eligible for full benefit Medicare and Medicaid, by creating Family Care Partnership. Currently, DMS contracts with three PIHPs to operate Family Care Partnership in 14 counties throughout Wisconsin. Family Care Partnership PIHPs provide or coordinate cost-effective and flexible services tailored to each member's needs. In addition to ensuring each member's long-term care service needs are met, members enrolled in Family Care Partnership receive acute and primary care coordination through the PIHP. Dual eligible Family Care Partnership members receive Medicare benefits through the PIHP. DHS provides the PIHP with a monthly payment for each member, and the PIHP uses these funds to provide and coordinate services for all of its members. Each Family Care Partnership member is the essential member of his or her own interdisciplinary care team. The team works directly with the member to identify the member's needs, strengths, preferences, and available resources in order to develop a person-centered plan. The person-centered plan may include help from natural supports (for example: family, friends, neighbors). When a member does not have natural supports available, the Family Care Partnership PIHP will purchase the necessary services for the member.

Activities and Interventions	Payment strategy: pay-for-performance Delivery system and person-centered care: • Performance improvement projects • Member-centered care plan • Care management reviews • Independent file review Member engagement and choice strategy: • Member satisfaction survey • Adult long-term care functional screen • PIHP Member Advisory Committee
Next Steps	The Family Care Partnership program will continue to focus on quality improvement, including continuing and developing new pay-for-performance initiatives; keeping members healthy, safe, and supported in the community for as long as possible; providing more support for behavioral health; and supporting competitive integrated employment. These activities and interventions, which are and will continue to be implemented in Family Care Partnership, are also discussed in the DMS Quality Strategies Section.

7. Quality Assurance

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

a. Access Standards

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

i. Network Adequacy: § 438.340(b)(1)

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

Acute care: To monitor network adequacy and availability of services, DMS has established distance and waiting time standards for different provider types in the contract (for example: primary care, hospital and urgent care access, behavioral health, and dental care). BadgerCare Plus and SSI HMOs submit electronic provider files on a monthly basis, which are stored in the

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

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

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

Children's services: PIHPs that serve children are required to meet all network adequacy standards set by CMS and DMS, including distance and waiting times established in the contracts. DMS is working with the external quality review organization to ensure the network adequacy requirements from the Medicaid managed care rule, § 438.340 and 438.68, are met.

DMS is working with PIHPs to develop innovative technological solutions, including telemedicine and e-visits. Within their policies, administration, provider contracts, and service practices, each PIHP is required to incorporate the values of honoring each member's beliefs, being sensitive to cultural diversity, and fostering staff and provider attitudes and interpersonal communication styles that respect each member's cultural background.

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

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

i. Evidence-Based Clinical Practice Guidelines

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

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

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

Children's services: Article X, Section B10 of the Care4Kids contract, Article X, Section 3b of the Wraparound Milwaukee contract, and Article X, Section 3f of the Children Come First contract describes the requirement for HMOs to develop or adopt best practice guidelines in accordance with § 438.236 (b) and to disseminate those guidelines to all providers and members upon request.

ii. Members With Special Needs

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

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

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

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

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

Children's Services: Pursuant to § 438.208(c)(1), the DMS definition of members with special needs in acute care programs is based on the terminology used in clinical diagnostic and functional development. Care4Kids special needs members include individuals who require additional assistance for conditions that may be medical, mental, developmental, physical, or psychological. All members in Children Come First and Wraparound Milwaukee meet the definition of an individual with special health care needs pursuant to § 438.340.208(b). The program design and scope of services in these programs are individualized and intended to meet these special needs.

iii. Transitions of Care Policy

Acute care: There are several aspects to transitions of care within the BadgerCare Plus and Medicaid SSI HMO program and below is a summary of the contract requirements for HMOs:

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

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

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

Long-term care: Each Family Care and Family Care Partnership PIHP is contractually bound to maintain a transitions of care policy for their agency (Article IV.C.2). The full details of each PIHP's transitions of care policy can be found within their internal policies and procedures. Each policy is reviewed and approved by a DMS long-term care oversight team, which consists of a contract coordinator and member care quality specialist. When a Family Care or Family Care Partnership member requires a transition of care, PIHPs assign care teams to review and assess the member's transitions, such as from hospital to home or nursing home to home. When a transition of care occurs, it must be specifically documented in the member assessment and member-centered plan. As needed, the DMS long-term care oversight team may coordinate discharges from facilities and is responsible for ongoing monitoring of the transition, as needed.

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

iv. Health Disparities

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

1. Data Infrastructure

DMS plans to implement a rigorous process to identify health disparities, execute data-driven interventions to address these health disparities, and evaluate the impact and effectiveness of such interventions. As part of the current enrollment process, DMS has the ability to collect member demographic data, including age, sex, race, ethnicity, primary language, and disability status, which is stored in the Medicaid Management Information System. Members are not required to provide race, ethnicity, and primary language information for enrollment at this time. However, managed care plans can collect additional data as they provide care management and deliver services to enrolled members to better identify members at risk of poor outcomes. Changes to the enrollment process and to the Medicaid Management Information System are underway. The changes will enhance the collection and use of demographic data for identifying and reducing health disparities.

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

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

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

2. Interventions

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

3. Community of Practice on Cultural and Linguistic Competence

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

4. CLAS Standards

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

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

5. Performance Improvement Projects (PIPs)

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

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

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

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

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

The following outlines the quality assessment and performance improvement programs intended to improve access, quality, or timeliness of care for managed care members.

Acute care: The acute care Quality Assessment Performance Improvement program guidelines are within Article X of the BadgerCare Plus and SSI HMO contract and further detailed in the

annual HMO Quality Guide. At a minimum, this program complies with § 438.330(b). Through the Quality Assessment Performance Improvement program, HMOs are required to:

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

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

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

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

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

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

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

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

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

i. Performance Improvement Projects

Acute care: Article X of the BadgerCare Plus and SSI HMO contract and the annual HMO Quality Guide requires HMOs to have performance improvement projects to address the specific needs of the population enrolled in the HMO. All BadgerCare Plus and SSI HMOs are required to submit two performance improvement projects each year. HMOs that only serve the BadgerCare Plus population are required to submit PIP proposals on two different topics. HMOs that serve both BadgerCare Plus and SSI are required to submit one performance improvement project for each population, and for 2021, are required to focus on reducing health disparities. The specific requirements of the performance improvement projects are described within the HMO quality guide and within Article X of the Badger Care Plus and SSI HMO contract.

Long-term care: All Family Care and Family Care Partnership PIHPs are contractually required to identify and conduct two performance improvement project per year (Article XII.C.7). Beginning in 2020, PIHPs may choose to design and conduct one or both projects over a given two year contractual period. One performance improvement project must focus on a clinical topic while the second project must have a nonclinical focus. The respective topics must be applicable to member quality improvement needs as assessed by each PIHP. Further, contractual Member Advisory Committees provide an active means for member input related to topic identification and selection.

When systems improvements are implemented through performance improvement projects, the specifications for monitoring and assessing the implemented change must be developed and adopted in compliance with the standards specified in the CMS protocols for performance improvement projects[13]. When a performance improvement project is undertaken by each PIHP, the PIHP develops the process and measures for monitoring and assessing system design changes, which are approved by DMS and validated annually by the external quality review organization. If the performance improvement project is a statewide project, the process and measures for monitoring and assessing system design changes are selected by DMS and will also include consultation with the external quality review organization and the PIHPs.

In 2020, the PIHPs implemented the following PIPs:

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

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

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

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

d. External quality review organization: §§ 438.340(b)(4) and 438.340(b)(10)

DMS contracts with an external quality review organization to conduct ongoing evaluations of the quality of services arranged for or provided to BadgerCare Plus and SSI HMO members in accordance with Article X, Section B7 of the BadgerCare Plus and SSI HMO contact, Article XII, Section D of the Family Care and Family Care Partnership PIHP contract. Article X of the Care4Kids contract, and Article IV, Section X10 of the Wraparound Milwaukee and Children Come First contracts. The goal of external quality review organization activities is to review and validate whether each HMO and PIHP is in compliance with federal and state requirements. These activities are performed consistently to ensure compliance with Medicaid provisions under Subpart E of § 438.340 and CMS protocols for use in external review of Medicaid PIHPs and pre-paid health plans. The external quality review organization findings provide a basis for DMS actions toward HMO or PIHP compliance remediation or quality improvement.

Primary external quality review organization activities include quality compliance reviews that are focused on enrollee rights and protections, quality assessment, and grievance systems; care management reviews; performance improvement projects and performance measures validations; and information systems capability assessment. The EQRO completes an annual report of their oversight activities for each program, which is posted publicly on the DMS' website for transparency. Each PIHP also receives their own individual annual report. While § 438.362 allows for states to exempt plans from EQRO review if they are contracted by both Medicaid and Medicare, DMS does not allow this exemption. All HMOs and PIHPs are subject to EQR0 review.

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

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

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

Long-term care: DMS works with the external quality review organization to develop the standards against which it evaluates PIHP performance. DMS also coordinates with the external quality review organization to ensure that the review process addresses changes within the PIHPs, including expansion to new areas and mergers. DMS long-term care oversight teams review all annual external quality review organization reports. The teams identify and analyze issues that affect the overall long-term care system and recommend potential quality

improvement strategies. Strategies are presented to long-term care managers and are prioritized based on the impact of the issue on:

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

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

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

i. Accreditation Deeming Plan: § 438.360

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

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

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

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

e. Remediation Plans

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

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

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

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

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

i. Intermediate Sanctions

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

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

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

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

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

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

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

Children's Services: Article XIII, Section C, of the Care4Kids contract and Article XIV, Section C of the Wraparound Milwaukee and Children Come First contracts First identifies remedies for violation, breach, or nonperformance of contract and describes the sanctions and intermediate sanctions that are allowable in accordance with § 438.340 (b)(7) for failure to comply with the PIHP contract.

8. Appendices

a. Quality Framework

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

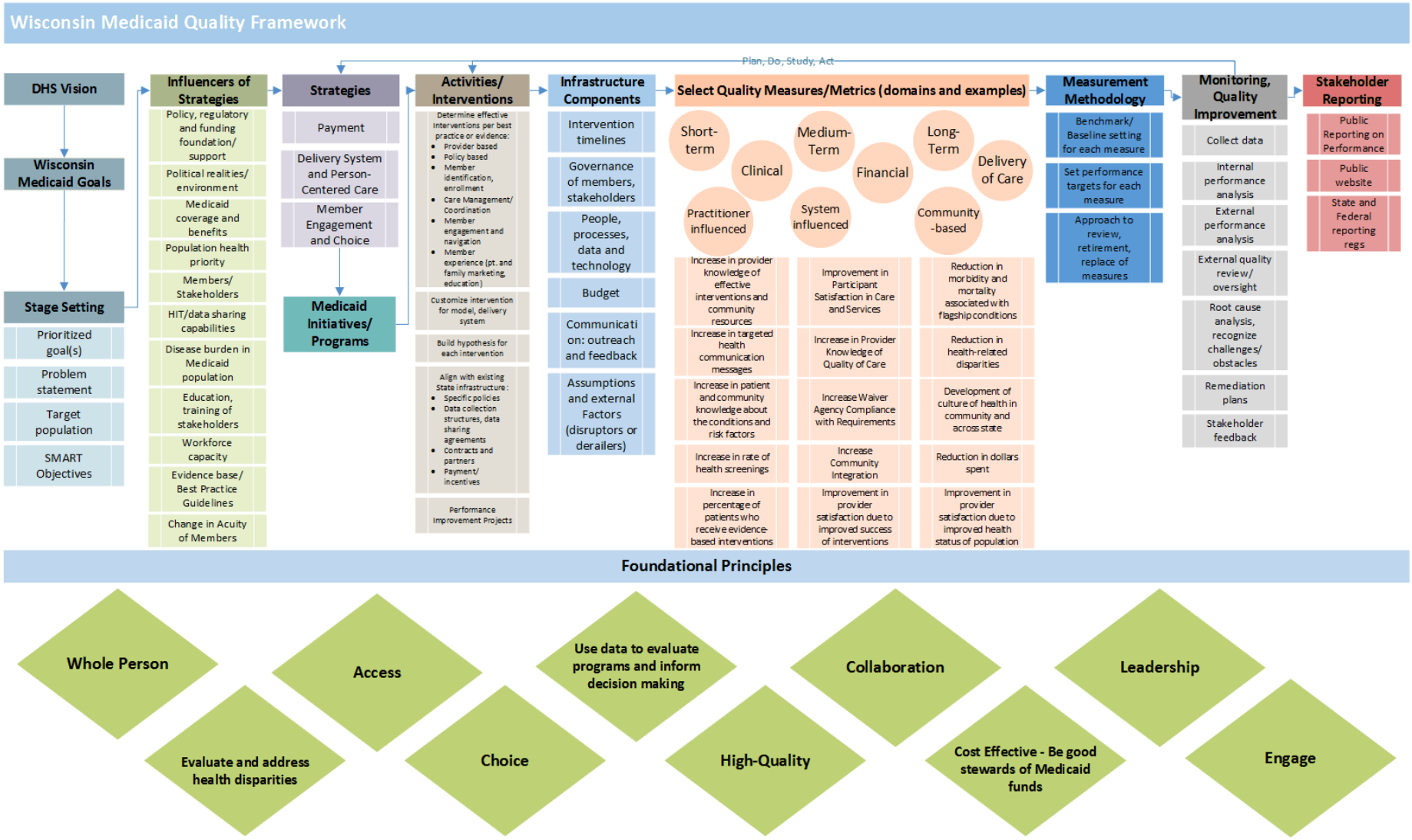
The quality framework includes 13 domains listed and described below:

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

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

The quality framework provides value to an organization by establishing a shared process and structure for programs, from initial program development to ongoing analysis, review, and

refinement. The quality framework allows for individual program variation, but connects back to the larger enterprise quality goals and objectives. Application of the quality framework across programs can help identify gaps and begin to address challenges.


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

b. Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health maintenance organization (HMO): An HMO is a type of managed care plan where an insurer offers comprehensive health care services delivered by providers. These providers may be

both employees and partners of the HMO, or they may have entered into a referral or contractual agreement with the HMO for the purpose of providing contract-related services for enrolled members. HMOs provide managed care to BadgerCare Plus and SSI members.

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

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

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

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

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

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

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

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

Managed Care Organization/Prepaid Inpatient Health Plan (PIHP): Each PIHP receives a per-person/per month payment to manage care for their members, who may be living in their own homes, group living situations, or nursing facilities. Long-term care PIHP refers to the

activities performed by long-term care managed care plans. PIHPs are responsible for assuring and continually improving the quality of care and services consumers receive.

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

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

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

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

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

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

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

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

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

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

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

- Performance measurement
- Incentive design
- Transparency and consumer engagement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Quality Measure Matrix

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

i. Acute Care

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

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

Core reporting measures for BadgerCare Plus HMOs:

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

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

Core Reporting Measures for SSI HMOs:

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

SSI Care Management Initiative Measures:

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

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

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

Care4Kids Measures:

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

ii. Long-Term Care

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

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

EQRO Quality Compliance Review

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

EQRO Care Management Review

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

Wisconsin Long-Term Care Scorecard Report

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

MCO Satisfaction Survey

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

d. Summary of Current Enabling Data and Technology Assets

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

- *Encounters and claims:* BadgerCare Plus and SSI HMOs and Care4Kids must submit compliant encounter data files in a HIPAA compliant ASC X12 transaction format. To do so, they must have a system that is capable of processing claims, submitting compliant encounters, monitoring enrollment and disenrollment, and reporting requirements. Children Come First and Wraparound Milwaukee are developing necessary infrastructure to submit encounters in 2021.
- *Member and provider enrollment:* BadgerCare Plus and SSI HMOs must submit a detailed provider network and facility file, and must use only those providers that have been enrolled with Wisconsin Medicaid. All HMOs receive monthly enrollment file data provided by DMS. All members in Family Care and Family Care Partnership are enrolled through the state. To qualify for Family Care and Family Care Partnership, the participant must meet both functional and financial requirements. DHS maintains all data on each member enrolled in the program that are collected through the state interChange (Medicaid Management Information System) system, encounter data, and the functional screen.
- *Surveys:* The acute care program area collects periodic information from BadgerCare Plus and SSI HMOs through surveys and uses the CAHPS Survey for members (see DMS Managed Care Programs section). Family Care and Family Care Partnership collect information through the use of an annual member satisfaction survey through an impartial third party.
- *Public and private registries:* The BadgerCare Plus HMOs, SSI HMOs, and Obstetrics Medical Home providers have a self-developed registry, hosted by the external quality review organization, to share information between HMOs, clinics, and DMS acute care program staff.
- *Stakeholder-reported data:* Acute care program staff collect health care effectiveness data and information set (HEDIS)-audited measures from HMOs, as well as periodic written reporting and performance data for various programs.
- *ACCESS:* ACCESS is a self-service internet-based application that allows the public to enroll in public assistance programs, including Medicaid, BadgerCare Plus, FoodShare, Child Care, and W-2. ACCESS includes functionality that allows members to screen for benefit eligibility, apply for benefits, check the status of benefits, report a change, renew benefits, and submit documentation. It is available online to citizens 24 hours per day, seven days per week. The ACCESS portal includes the functional screen for long-term care members. There is also a mobile application called MyAccess available to members for program information and enrollment convenience.
- *Client Assistance for Re-employment and Economic Support System (CARES):* Wisconsin's highly integrated system that uniquely identifies individuals and efficiently shares data across multiple eligibility programs and work programs. The Wisconsin CARES system enables workers in all Wisconsin counties and tribes the ability to perform automated eligibility

determination, benefit calculation, and case management for applicants applying for Medicaid (including long-term care and SeniorCare prescription drug program), BadgerCare Plus, FoodShare, Child Care Assistance, TANF, and Caretaker Supplement program.

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

information and to communicate with providers. Electronic health records systems can also be patient portals used by health plans to connect with members for billing, care alerts, and other purposes.

- *Care coordination software:* Most BadgerCare Plus and SSI HMOs have technology to help document care coordination and member care plans; however, this software varies by HMO. All Family Care and Family Care Partnership PIHPs have and maintain care coordination software to document care provided and to maintain the current member-centered plan. The software varies by PIHP.
- *PIHP management information system:* Each long-term care PIHP must maintain a health information system that collects, analyzes, integrates, and reports data on utilization, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility.
- *Information exchange system:* Long-term care PIHPs report data, as requested by DMS, through the information exchange system. In addition to encounter reporting, uses of this system include incident reporting, restrictive measures reporting, and competitive integrated employment reporting.
- *Secure file transfer and secure portal:* BadgerCare Plus and SSI HMOs must have a secure ForwardHealth Portal account to access data and reports, maintain information, conduct financial transactions, and other business with acute care program staff.
- *Wisconsin Statewide Health Information Network (WISHIN):* Wisconsin's health information network that shares electronic health information securely between participating physicians, clinics, hospitals, pharmacies, clinical laboratories, PIHP and HMOs across the state.

e. Quality Strategy Public Comments

The draft Quality Strategy document was made available April 22 through May 21, 2021 for comment by stakeholders and the public through a number of outreach efforts. These outreach efforts include presentation to advisory committees and councils, presentation to the Medical Care Advisory Committee, tribal consultation, publication on the DHS website, newspaper announcement, and GovD notice. Meeting minutes from the Medical Care Advisory Committee discussion on the Quality Strategy can be found here. 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 23 public comments received, based on common pieces of feedback expressed by multiple comment submitters. Comments are numbered in Table 6 and associated with common themes below:

- Remove duplication of MCO and provider services (see comment 6, 7, 13, 15, 21, 22)
- Address provider rate adequacy (see comment 7, 8, 13, 15, 22)
- Improve functional screen (see comment 4,10, 22)
- Establish partnerships with providers (see comment 3, 20)
- Reduce unnecessary compliance burden for providers (see comment 3, 20)
- Improve plans for reducing disparities and enhancing cultural competence (see comment 18,19)
- Focus on continuity of coverage and care (see comment 18, 21)

TABLE 6 2021 MEDICAID MANAGED CARE QUALITY STRATEGY PUBLIC COMMENTS

1	I am commenting on the care. I have a great doctor not complaining about him. But it would be nice if I received the checks of health care in the exam that I used too. My ears, my heart and things like that.
2	As a behavioral health provider, I can say that several of your HMOs do not follow the rules as required. UHC doesn't allow 60 min sessions without authorization which is nearly impossible to get. BCBS doesn't allow QTTs even though BadgerCare itself does. Group Health also requires authorization and those are very difficult to obtain. They limit sessions at 6 otherwise send even with authorization, they will only allow a certain number of sessions. I cannot say enough good things about Security Health Plan. They are wonderful to work with.
3	Regarding quality reviews of Medicare and Medicaid in the state of Wisconsin. I have just a few comments. 1) The reviews are very important not only for the safety and health of those who receive care in Wisconsin. They are also important for the health care providers and health care plans as a way to confirm if they are doing well or not. Please do not do away with these reviews! 2) Given the extreme challenges of Covid 19 and the immense burdens we have recently placed on the direct health care staff, I strongly recommend that the quality review

	programs avoid adding to the burden of the direct care providers over the next few years. QA can be done by reviewing data provided by the various health care programs and can be done by briefly interviewing health care providers. We do not need to ask the health cares systems to create extra QA projects. They have enough on their plate right now. 3) Finally, I recommend that those employees of DHSDMS involved in doing the QA reviews of health care providers in our state, make a major effort to include the providers as partners in the effort to improve the delivery of health care. There is a discomfort and even fear experienced by many health care providers when someone from state or federal government comes in to "Judge" their work. In the final analysis, we are all working together to improve health care and this should be emphasized in the QA process. Thank you for requesting comments about the medicaid and medicare QA process in Wisconsin. I was a nursing home inspector, a health care policy analyst, a health care QA reviewer and a health care fraud investigator for the State of Wisconsin many years ago. I know how important the QA process for medicare and medicaid is and I know some of the challenges that exist. You all have my best wishes for success as you help develop a better system for the people of Wisconsin.
4	Boll Adult Care Concepts specializes in the care and treatment of individuals with chronic mental health, personality disorders, emotional issues and poor life choices, including substance abuse. We have both residential and community supportive home services. Our residents in our Adult Family Homes qualify for family care benefits due to medical criteria or developmental disability. What makes them unsuccessful living independently is the untreated or undertreated co-occurring chronic mental health, personality disorders, emotional issues and poor life choices. They have never been successfully taught how to manage their mental health symptoms. The Managed Care Organization in our county has recently enacted a new Rate Methodology. This Rate Methodology consists of 2 factors. Residential Services offered and Resident Acuity. I have great concerns about the Functional Screening Tool that is used by the Managed Care Organizations to determine acuity. This tool does not adequately address the needs of someone with mental health symptoms / issues. The 2 questions that stand out are: how often do you self-harm? How often do you harm others? Those assessment questions are so stereotypical of someone with a mental health. I had one resident with a diagnosis of schizophrenia and a history of significant lifelong sexual abuse tell me she thought those questions to be offensive. The remainder of the questions are somewhat irrelevant to some who main difficulty is that they hear voices or have ritualistic schizophrenic behaviors or that their personality disorders make them undesirable to life with or if left unchecked, dangerous to the general public. The assessment tool should be revised to be inclusive of measures such a symptom stability, structure, supervision, teaching symptom management, healthy lifestyle in conjunction with medication therapy.

	In one setting or another, I have been providing mental health care and treatment my entire career. I am soon approaching retirement age. I have been running Boll Adult Care Concepts since 2004. This new Rate Methodology has reduced the residential rates to a few dollars more per day than what I was reimbursed 17 years ago. In this climate of COVID and Caregiver shortages, these programs are not sustainable, especially to the Medicaid eligible patient. I have been a mental health advocate for 40 years. I would be happy to discuss this very important topic. Thank you for your time.
5	Thank you for the opportunity to provide feedback on the 2021 Wisconsin Medicaid Managed Care Quality Strategy. I appreciate DHS's efforts to collect feedback from the public on this important document. A. Page 11. Foundational Principles *Comment - Pure person-centered care is difficult to achieve if there are service outcomes associated with Paid for Performance (P4P) measures. P4P should be tied to member satisfaction, safety, and service efficiencies; not service outcomes that may or may not be "centered" for every person/member. It is particularly concerning that P4P financial incentives are a significant part of MCO future strategy. To ensure quality service plans are written for members, P4P should not be associated with any particular program or service outcome, rather, it's focus should be on more global issues that impact all members.* B. Page 11. Foundational Principles-Choice *Comment - Recommend first sentence reads as, "Empower people with access to the full array of services and supports".* C. Page 11. Foundational Principles-Choice *Comment - Recommend first sentence read as, "Engage people to make meaningful choices about where and with whom they live, work, and their services and who provides them."* *D.* Page 20. Objective 3 *Comment - Recommend this Objective to read as, "Increase the number of people who independently choose their services."* *E.* Page 20/21. Objective 5b *Comment - This entire objective should be eliminated and not used as a measure of success consistent with Family Care's foundation of person-centered planning. Increasing the percentage of people to work in one setting over another will inevitably result in forced goals and plans. This is not a measure of "community inclusion". DHS should allow the person served to decide how they define their community. If DHS uses*

	person-centered planning as a foundation and driving principle of Family Care, then the Member should define their community. Anything other than this is not person-centered and at a minimum shouldn't be used as a prescriptive measurement of quality. F. Page 40. Paid for Performance *Comment - Using service-specific outcomes as a measure of success for Funders to achieve (note: not a measure of success for Members to achieve) in order to receive a financial incentive is not appropriate, nor is it a measure of quality. P4P should be based on achieving global initiatives such as Goal #3 "Choice and Control: Increase the percentage of people who independently choose their services". This objective example and others associated with safety and equity, would be more reflective of an area MCO's should strive to work toward in order to obtain a financial incentive. Correlating Funder financial incentives to Member outcomes has significant potential to strip away the basic principles person-centered planning. Further, P4P can result in service plans biased toward P4P outcomes and away from desired or necessary services.* G. Page 26. 3.1.2 Percentage of adults in the I/DD population working in a non-workshop setting. And 3.1.3 Percentage of adults in the PD population working in a non-workshop setting. *Comment - This is not a measurement of quality, rather it's a personal member choice. This is an inappropriate quality indicator and should not be used in this context considering the Employment First Act in Wisconsin recognizes the importance and appropriateness of pre-vocational services. Also, this measure does not support the principles of Family Care relative to person-centered services. If a Member does not want a "non-workshop" setting, it should be not be considered a negative outcome, rather it should be recognized as the person making an independent choice on how to spend their day.* H. Page 32. Last paragraph; sentence: "Competitive Integrated Employment can improve individuals' quality of life, self-determination, and community engagement". *Comment - It should be noted that ANY employment can improve individuals' quality of life. While competitive employment is an important and appropriate objective for some, not all individuals find that an appropriate employment setting outcome, nor a defining characteristic of their community.* I. Page 35/36. Member Engagement and Choice Strategies *Comment - The first sentence of this section would be a true statement if P4P were focused on satisfaction, safety, efficiency, and the other principles of Family Care, not service-specific outcomes that apply to a few Members. Enforcing service outcomes to be aligned with financial incentives to Funders, creates a false sense of person-centered planning, often clouded by the desire of a Funder to receive the incentive.* J. Page 37. 3rd paragraph *Comment - Community in this context needs to be understood as "defined by the Member".* K. Page 37. Final sentence on this page.

	Comment - To be consistent with Act 178, this sentence should include the provision of pre-vocational services. L. Page 47. Next Steps: "The Family Care program will continue to focus on quality improvement, including continuing and developing new pay-for-performance initiatives…". *Comment - Current and new P4P initiatives should focus on Member satisfaction, safety and service efficiency as opposed to service-specific outcomes that do not apply to all Members.*
6	As a professional who has worked in a hospital, MCO and SNF setting, and the sister of a person with disabilities who is enrolled in an MCO I have a few thoughts I would like to share about the Family Care Program. Is a nurse and a social worker really needed for each member? Certainly there are individuals who have complex medical care needs that may benefit from both an RN and social services case manager. However, I think that there may be an opportunity to have a system where team assignments are more needs based. For example, a relatively healthy person with intellectual disability may only require the assistance of a case manager. Or a person with physical disabilities who has a good support system may do well with only an RN case manager. It seems that in many cases, my own family member's as an example, a nurse and social services case manager are not necessary. Why is family care enrollment extended to long term SNF residents? SNFs have always been highly regulated. Having an MCO team to coordinate with and update in addition to the resident and supports and legal representatives takes up valuable time and resources for SNFs. When the resident has no goal/plan/intent/desire to discharge from long term SNF care it does not make any sense for the MCO to be involved. The added strain to the SNF teams, residents and families is just not necessary. Thank you for the opportunity to provide feedback.
7	I recently solicited comments from my team on some of the challenges and issues we face with the family care program. Attached is a summary of the issues that were presented to me. Your request for public comment is timely. Let me know if you would like to have further discussion or have any questions about the issues shared. Reimbursement • There is nothing in the MCO contracts that stipulate a pass through of rate increases to the providers (CBRF's, ADS). There has little movement on rate increases over the years and, in some cases, we have had rate decreases (see reimbursement history below). We are currently deciding on the feasibility of opening adult day services and, with the majority of our adult day participants being covered under MyChoice, the most recent rate decrease makes it difficult to open. It, in essence, wipes out any margin we had in that program. • Community Care family care- we met with [name redacted] on March 11, 2020 about an increase and during that meeting he said we were one of the highest contracted

CBRFs. They cap CBRF at 3100/month and we are at/above that. So he said they lose money on us.

- Like Medicaid, the contracted rates do not come close to covering the cost of care.

COMMUNITY CARE

	2009	2011	2014	2018	2021
ADS - Moderate	52	49.4	49.4	49.4	49.4
ADS - Intensive	57	54.15	54.15	54.15	54.15
Bathing w/ assist	15	15	15	15	15
Bathing no assist	14.5	14.5	14.5	14.5	14.5
CBRF - Care & Sup	97.36		97.36	97.36	128.76
CBRF - Room & Board	25.97		25.97	25.97	
CBRF Respite	123.33		123.33	123.33	128.76
Room Retainer					31.4

MY CHOICE FAMILY CARE

2013 MCFC	2016	2018	2019	Proposed 2021	
ADS - 1 Day	52.75	52.75	52.72	55.4	53
ADS Memory Loss Program	37	37	37	45	N/A
Daycare Mbr Bath	16	16	16	16	16
Comm Mbr Bath	21	21	21	21	20
Glucose, Catheter,etc	5	5	5	5	5
CBRF - Support Services	90	90	92.5	92.5	125

CBRF - Room & Board	22.2	22.2	24	24	

Duplication/Redundancy of Services

- Social Worker here and Case manager with Family Care. When someone is staying LTC, there really is no longer a need for both. Same for the RN
- SNF holds Care conferences every quarter, but Family Care also is required to do reviews/patient visits. Unfortunately these don't always line up with the quarterly review dates, so we are at times having multiple meetings to accommodate Family Care's needs
- On the CBRF side, we do their job. They call our nurse for full nurse reports and expect her to run and take vitals when the FC org says the nurses should be coming in and taking vitals and laying eyes on their members. We rarely ever saw a nurse and rarely did they even speak to the resident to get to know them, much less do nursing assessments. We do set boundaries with them, but the turnover is so great that there is no continuity of care.

Discharge Planning

- Lack of consistency in the discharge planning process. Sometimes transportation and DME is set up by the family care case worker and sometimes it is left to us, Difficult to navigate without running the risk of duplication
- When a client is looking at an alternate facility, the LH social worker will send in the referral, but the case manager will also send in information that isn't always accurate or up to date, which can cause confusion and delay the d/c process
- Discharge planning/alternate placement is a very slow process. For example, when someone needs to be placed/relocated the case manager has to make a referral in through their placement team and they are given a list of options (based on dx, medications, case notes, etc.), then it is the CM's responsibility to place them based on that list- it can take quite awhile for that list to even be generated, let alone then working with the family to find the best fit for the resident. Sometimes by the time this comes to fruition, the resident has declined and the list of options are no longer appropriate.
- Family Care strives to find environments that are the least restrictive to the Client. I feel like they are striving to keep people out of SNF's because they are costly for FC, and they want to keep individuals in the community. This can cause difficult conversations and be frustrating for all parties, because the family/resident may want to stay here, but Family Care is pushing for them to discharge. This then though circles back to the placement process and the amount of time it takes, so then the resident may end up staying anyway.
- It seems like there is not always a lot of motivation to expedite the discharge planning process. There is a high turnover of FC caseworkers, they have high case loads, and they can be quite challenging to work with-not following up or returning calls, not meeting deadlines, etc.

Contract Renewal/Recertification

- Cumbersome and a duplication of the survey process. Asking for protected information that we should not be providing (specific employee file and background

	check information) Credentialing is extremely time consuming and duplicates what the state is already looking for • This year's credentialing requires CBC/DOJ/BID reports for employees which we have not complied with out of concerns for privacy • Issues with contacts. Contacts are constantly changing which makes it hard to follow-up on contracts and negotiate rates. FC Eligibility Process • Medicaid applications are taking about 4-5 months to get eligibility, and then we (social services/business office) make the referral to Office on Aging. Office on Aging makes contact with resident/family and that can take a few weeks. They must see the applicant in person which has been difficult during COVID. The Office on Aging completes their paperwork, resident/family is given a packet to choose the MCO: My Choice or Community Care. Then the MCO's paperwork must be done which can take a month or more. • There have also been issues with the MCO dropping coverage at renewal without informing the provider of services (us). All communication goes to the MCO about the renewal and when it is due. MCO works with family but doesn't include the facility until they are ready to dis-enroll the member due to not giving MCO all paperwork needed to complete the renewal. We find this out through an email from the portal that tells us to login as a member is being dis-enrolled. We do not know why this is occurring so we have to reach out to the case manager and wait sometimes 3-4 days to get a call back. If we were include early on in the process we could assist with getting the documentation needed so it is timely and complete. We have a stake in this process as we want to ensure the resident has a pay source and should be looked at as a partner in the process if they are struggling. • The second communication issue we have struggled with is not informing us that the resident/family is not paying the patient liability to the MCO. The MCO bills the resident/family and the facility is not part of these transactions. We do not find out there is an issue until the amount due is very old and large. Failure to pay the MCO will also invoke the member's dis-enrollment. Again if we new early one we might be able to head this off and get resident/family to pay the MCO timely. • Another issue we have with the FC eligibility process is how deviation is handled. If a resident converts to MCO before they have paid us in full there may be a need to continue the deviation of patient liability to pay our outstanding balance. MCO's will not cooperate with us on this. Before they transitioned to MCO we were paid the patient liability directly and can post it to the old balance. Now the MCO is being paid the patient liability and will not forward the money to us to pay our deviation. We have done a work around by requesting the deviation continue ourselves (MCO sees that patient liability go to zero) and work with the family to pay us directly until we are paid. Then when we are PIF we end the deviation and then MCO will see patient liability goes back up to income - $45 and begins being paid directly from resident/family. It would be nice if MCO was a partner in this as it can be complicated to the resident/family trying to follow who they should pay. If contract doesn't allow this to happen would like to see this written into new contracts.

	Other comments: • Communication is a huge barrier- they can be extremely difficult to get a hold of. Sometimes we don't hear from them at all during a rehab stay or for months with our LTC residents. We are not always kept in the loop on where things stand with placement. It definitely depends on the case manager/RN team. Families have difficulty getting assistance from the MCO as well and turn to us for help. We end up doing their job. We are expected to keep them informed regarding any incident, change of condition, etc. but they do not reciprocate the communication with us. • We are not notified if the case manager/RN changes for a resident • Lack of resident centered care. In late 2019, we had an Adult Day client whose payer source was family care and had been coming to the Lutheran Home Adult Day for ~12 years. The family asked if we would consider taking her in our new memory care. Of course we wanted to take care of her since she has been in our family of services for so long. We thought the Lutheran Home's new memory care would be the best spot for her continuity of care. The family was thrilled that we could take her. Unfortunately our team was told that FC was going to pursue the other facility that had already accepted her. The placement team stated our contracted rate was higher and they were already in process with the other facility. She ended up failing in that CBRF and coming to us shortly thereafter for skilled nursing care. • On the SNF side, we can't transport resident ourselves must call the MCO to schedule. They need 48 hours or more notice. This can be complicate by the lack of communication from the case manager. Some of the vendors that are sent do not give good service to our residents. If they do not show up we are scrambling to get them transportation and we absorb the cost. Our staff call a week ahead of appointment to make sure there are less issues. That works if we know that far out there is an appointment. No urgent transportation (under 24-48 hr notice) is available so the facility must transport and absorb the cost. • On the CBRF side, the responsibility of transportation coordination and cost lies with the provider which further increases the cost of care • With Medicaid rate changes usually months behind we must get rate adjustment from the MCO's. This is requires us to create a spreadsheet with every month affect for every resident. This is time consuming. The MCO can take months to process the adjustment especially if we are due money. Would like to see MCO be required to identify the claims affected and send us the adjustments as traditional Medicaid does. • HCBS requirements do not make sense for the memory care environment
8	We have provided care to members of several MCO's since the inception of the program. We have struggled significantly with the rates of all our contracted MCO's. We just received our first increase since 2010 from one MCO. During that period of time, we experienced two rate cuts from our original contracted rate. Each year we asked for an increase, the reply from the MCO was consistent, "provide a 30 day notice if you don't find the rate sufficient to cover your costs." Clearly, not a good reply. We received a recent, significant rate cut from Lakeland. When programs are 70-85% Family Care, rate cuts are unacceptable, especially when we are taxed with providing increased services such as transportation. Providers must still maintain/pay for quality staff, health care benefits and other fringes. Competition for that staff requires paying competitive wages. How does that happen with rate cuts?

	At some point providers have got to stop bearing the brunt of the MCO's financial concerns/profit taking.
9	My name is [Name Redacted] and I am in support of the renewal of the Medicaid Managed Care Quality Strategy. I work with the Medicaid Program on a regular basis and believe that the Medicaid Program Provides Quality Services. I do have some concerns about the Managed Care system in Wisconsin because I believe that sometimes providers are more interested in saving money rather than providing quality services that meet the needs of individuals with disabilities. This happens more often with people who have higher level care needs which would cost more money for the Managed Care system to truly integrate them into the community. I help individuals with disabilities move into the community and deal with managed care providers who would rather keep individuals in nursing homes rather than provide support in the community. My consumers and I are constantly having to challenge decision and these consumers ultimately end up in the community doing quite well with the supports provided to them. After the initial outlay of expenses supporting people in the community is cheaper and meets consumers needs for higher quality care and a better lifestyle.
10	Please see below for points of emphasis for comments and possible solutions on issues for issues relating to MCOs: Rate adequacy/functional screen The functional screen is not something that truly captures what the resident needs. For the majority of functional screens, we see that the screener asks the RESIDENT the questions about their abilities; not actually the staff providing cares. Unfortunately, what we see for a majority of the screens is residents not sharing correct or accurate information. Example: When you ask a gentleman if he needs assistance from a caregiver (who is typically a female) with incontinence, he with pride states often that he could do it himself when really, the individual is not providing that care appropriately. We also see, with COVID, that the functional screeners are not at facilities doing the screening. They are doing this over the phone. If they were seeing the individual in person, they may get a better idea. However, even before COVID, it was often where they would not be doing a full functional assessment of the individual. These assessments also take over an hour sometimes. If we have a resident who has cognitive impairments, we have to have a nurse or aide sit with the resident while they are on the phone with the screener. This is a redundancy in the care management process. It also wastes caregiver time in our facility having to be involved in a really inefficient process. When it comes to residents who are already in house and need more cares, the screening process to get the new rate needed for the change of condition is very untimely. We have seen these anywhere between 30 to 60 days at times just to get the screening completed and then waiting for someone to provide the rate letter. These items noted above results in an inadequate rate for the care that is being provided. IDEAS FOR SOLUTIONS: Eliminate the position of screeners with MCOs allow the facility staff to complete functional screens on their own. MCOs could certainly provide

	the criteria for the functional screen, but allow facility staff to assist. This would allow for a more accurate picture of the resident and their care needs, save time and money for the MCOs, and then have the RN case manager do an onsite assessment of the resident if they feel that they need to ensure accuracy. Rate negotiation process I have not had the ability to negotiate a rate at any point with an MCO. We don't get to see the functional screen even to know where the rate came from and how that is determined. The rate adequacy and the functional screens are the biggest areas of concern for me or areas where I would suggest improvement.
11	My Choice Wisconsin reviewed the Quality Strategy materials. We have no comments or feedback at this time.
12	MyPath submits these comments regarding the draft Medicaid Managed Care Quality Strategy (the 2021 Draft) prepared by the Division of Medicaid Services (DMS), Wisconsin Department of Health Services (DHS). Who We Are MyPath brings the perspective of nearly forty years of experience providing Long-Term Services and Supports (LTSS) for individuals who have Intellectual or Developmental Disabilities (I/DD) and who are supported under Family Care. We offer LTSS through four affiliates: Homes for Independent Living of Wisconsin, Prader-Willi Homes, Paragon Community Services, and Genesee Lake School. • Homes for Independent Living of Wisconsin (HIL) supports 410 individuals enrolled in Family Care throughout 12 counties in Northeastern, Southeastern, and Central Wisconsin. HIL specializes in serving people with high behavioral needs, as well as individuals with significant physical and cognitive needs. • Prader-Willi Homes (PWH) is the nation's largest provider of residential services and supports for people with Prader-Willi Syndrome, a rare genetic disorder characterized by issues with emotional regulation, difficult behaviors, and life-threatening metabolic symptoms. Along with residents from other states, PWHO supports 37 individuals who are funded by Family Care and who live in or near Waukesha County. • Paragon Community Services (PCS) offers day programs and community respite to 237 Family Care members at six locations in Northeastern and Southeastern Wisconsin. 73 of those individuals are also supported in HIL residential settings. • Genesee Lake School (GLS) is a national leader in providing therapeutic services for children with developmental disabilities and behavior disorders. Three of its students, between 18 to 21 years of age, are supported by Family Care. In total, MyPath offers services to 614 Family Care members, empowering them to live their best lives in the community. This represents about 2.65% of the I/DD population enrolled in Family Care. MyPath does not provide Acute Care services. Our comments focus on those sections of the Draft that relate to quality strategies for Family Care members who fall into the I/DD category.

Summary

1. Recommendation #1: Annotate and explain the differences in approach between the 2021 Draft and the 2018 Medicaid Managed Care Quality Strategy.

2. Recommendation #2: Retain the explicit objective from the 2018 Strategy of reducing length of stays for Family Care members in Institutions for Mental Disease .

3. Recommendation #3: Broaden MCO Pay for Performance incentives around quality improvement to reflect the needs of members with I/DD.

4. Recommendation #4: Align the goals in the 2021 Draft and quality goals developed by the Division of Quality Assurance for Long-Term Care settings.

5. Recommendation #5: Create a pilot for a medical home that would integrate Acute Care and Long-Term Care for a targeted I/DD population with significant medical needs.

Recommendation #1: Annotate and Explain the Differences in Approach between the 2021 Draft and the 2018 Medicaid Managed Care Quality Strategy.

DMS last prepared its Medicaid Managed Care Quality Strategy in 2018 (the 2018 Strategy). That document highlighted four domains: (1) access to care and services, (2) cost- effectiveness, (3) person-centered care and member experience, and (4) health outcomes and reducing disparities.

While there is significant overlap between the 2018 Strategy and the 2021 Draft, there are also differences. For example, certain objectives listed in the 2018 Strategy no longer appear. Is that because those objectives were achieved? Or are they no longer considered to be the best means to attain that specific goal? It would be helpful to the public if DMS would note those differences and comment on the reasons for the changes.

Recommendation #2: Retain the Explicit Objective from the 2018 Strategy of Reducing Length of Stays for Family Care Members in Institutions for Mental Disease.

The very first stated objective of the 2018 Strategy was to "[r]educe the length of stay of Family Care and Family Care Partnership members in institutions for mental disease after the member is determined psychiatrically stable." The 2021 Draft has as a goal to reduce non-value-added services and unnecessary hospitalization readmissions for Family Care members1 but the
specific reference to stays by members in Institutions for Mental Disease (IMDs) has been omitted.

Unnecessary or extended stays in state institutions, when a Family Care member could live productively in the community, is a prime example of avoidable and expensive care that significantly interferes with quality of life. HIL has substantial experience in supporting people who present complex needs and significant behaviors, and who have experienced one or more episodes of care in IMDs. We deliver person-centered supports and sustainable behavior plans that significantly reduce the likelihood that individuals with a history of institutionalization will return to those settings.

A typical profile of an individual in this category might include very complex disorders, significant trauma background, a history of failed placements in multiple settings, one or

more periods of institutionalization, and provider staff burnout. In 2020, we made great progress toward the goal of offering these individuals a permanent place to live their best lives:

- 139 of 146 behavioral clients (95%) experienced zero days of placement at an IMD.

- These members spent 99.7% of their days either supported by HIL or on home visits (44,792 days in placement versus 119 days ofIMD confinement).

- 85.8% of the behavioral clients supported at any time in 2020 were still supported on December 31, 2020.

- For some clients, HIL has succeeded in reducing the number of staff hours compared to when they were first admitted or has supported their transition to a less restrictive setting. We achieved this-and thereby lowered rates-for 18 individuals last year.

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

For example, we opened several community-based crisis programs that offer more intensive supports so that individuals with high behaviors can stabilize before relocating to a more permanent home. We collaborated creatively with DHS and the MCOs to overcome obstacles to creating a setting that would offer better services. The program now serves as a critical safety net to prevent urmecessary stays in institutions, thereby improving the quality of care but at lower cost.

There are other ways to reduce length of stays in IMDs by members of Family Care. But we see four barriers to making this happen: staffing shortages, funding incentives, communication, and capacity.

First, the ability of providers to offer community settings for individuals who would otherwise be in an IMD depends on their ability to recruit and train qualified staff. There is no need to repeat here the litany of issues around the shortage of direct caregivers in Family Care. We simply note that this has a major impact on this issue, as it affects many other parts of Family Care.

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

	Third, communications gaps around planning for ultimate discharge delay transitions for Family Care members out of the IMD. The dialogue about where the member will go when treatment is complete often does not even begin until shortly before discharge is scheduled to occur. At that point, a mad scramble ensues to locate an appropriate provider. This points to a fourth barrier: provider capacity. Family Care members who require treatment at IMDs present challenging conditions and behaviors. Few if any providers can afford to hold placement spots open and unreimbursed, just in case they are asked to accept emergency placements of these individuals. Although HIL's crisis program offers transition services, its capacity is limited. Our ability to step down support from crisis level to a traditional community setting can be constrained by the lack of available beds and the need to develop new programs for those individuals. Several steps could be taken that would reduce the number and length of IMDs stays by Family Care members: • First, data on the number of Family Care members who are enrolled in IMDs should be shared, to focus attention on the issue and to highlight the scope of the problem. • Second, a group of stakeholders should be convened to discuss ways that financial incentives could be more closely aligned, consistent with federal and state regulations. Providers should be included in these conversations, as we know firsthand the types of supports that these individuals need to be successful-and the snowball effects that occur when they decompensate. • Third, a best practice should be implemented at IMDs that planning for discharge will begin immediately upon admission, not placed on hold until the individual is ready to leave the facility. Someone should be identified as the "owner" of the task of securing the next placement for the member. In those rare situations when an HIL client is referred to an IMD, we inform the Care Team that that we will accept the member into our program following the conclusion of treatment. Family Care service providers should indicate, upon admission, whether they will be able and willing to accept the member upon discharge. If the provider cannot do so, conversations could immediately begin around other possible providers, to promote the likelihood of a seamless transition to a community setting. • Fourth, the stakeholder group should consider ways to expand capacity. There is a need for additional crisis programs that can serve as stabilizers in the support system for these members, and that would prevent unnecessary IMD admissions. A method should be considered to dedicate some community settings so that there could be more flexibility when a discharge of a Family Care member from an IMD is imminent. And of course, we need to make progress in the drive to address shortages in the direct care workforce across the board.

We recommend that the objective stated in the 2018 Strategy to reduce stays by Family Care members in IMDS be reiterated in the 2021 Draft.

Recommendation #3: Broaden MCO Pay for Performance Incentives Around Quality Improvement To Reflect the Needs ofl/DD Members.

The 2021 Draft indicates that DMS will continue to pursue Pay for Performance (P4P) initiatives for Family Care. The 2021 DHS-MCO contract provides that one set of P4P incentives is associated with Assisted Living Quality Improvement. Along with other criteria, a payment may be earned for a Family Care member residing in an assisted living facility if the facility is in good standing of the Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL), and has a rate of less than 3 falls with injury per 1000 occupied bed days during 2021, as documented by WCCEAL. An initiative developed by trade associations and approved by DHS, WCCEAL sponsors a comprehensive quality assurance program. Its purpose is to improve the outcomes of individuals living in Wisconsin Assisted Living communities. Providers who emoll in WCCEAL through their trade associations can be certified as adhering to designated quality standards.

For people with I/DD living in the community, however, it can be problematic to rely on WCCEAL membership as an indicator of quality in assisted living settings:

- Those who decline to become members of one of the four senior living trade associations with approved WCCEAL programs are excluded.
- The focus of WCCEAL is quality improvement measures in larger assisted living communities. Approvals are made for each individual setting. Many people with I/DD live in smaller settings with one or two people. Those do not fit with the WCCEAL approach.

- A measure of falls per bed-days is not meaningful for many individuals with disabilities who are fully ambulatory and who are at no greater risk of falls than those without disabilities.
- The questions posed in WCCEAL member surveys reflect interests and preferences in a typical community that supports seniors. That is not the world of many people with disabilities served by Family Care.
- Relatively few providers of services for people with I/DD have maintained enrollment in WCCEAL.

To be sure, the DHS-MCO contract provides an alternative to the WCCEAL P4P incentive, which is that MCOs receive credit for members who live in a setting that is subject to an abbreviated survey by DQA. But currently there is little transparency regarding the list of providers and locations that have been given such abbreviated survey status-unless there is such a list that is shared with MCOs but not with the provider community.

We recommend that the P4P incentives adopted by DHS be broadened to include quality improvement activities by providers of services to people with disabilities, who fulfill the purpose and promise of allowing those individuals to live as independently in the community as possible.

	Recommendation #4: Align the Goals in the 2021 Draft and Quality Goals Developed by the Division of Quality Assurance for Long-Term Care Settings. The DHS Division of Quality Assurance (DQA) exercises regulatory oversight over Long-Term Care settings funded by Family Care, as well as by other funding sources. But the Draft is silent on the relationship, if any, between the quality improvement strategy to be overseen by DMS, on the one hand, and quality initiatives, policies and practices that DQA has already put in place. • DQA oversees compliance with the rules for residential settings based on numbers of beds, i.e., DHS Rule 83 for five- to eight-bed Community-Based Residential Facilities, and DHS Rule 88 for smaller Adult Family Homes. • DQA supervised the preparation of the State Transition Plan which outlines the State's program for complying with the Home and Community-Based Services Rule (HCBS) issued by the federal government. DQA is also responsible for confirming that Wisconsin Long-Term Care settings supported by HCBS waiver funding comply with the Rule. The HCBS Rule speaks to quality outcomes and program setting requirements that echo those articulated in the 2021 Draft: namely, to ensure that members are treated with respect and dignity, that they can exercise choice, and that they can participate fully in community life. We support moving toward a stakeholder consensus on the quality outcomes that will govern services for Family Care members. When multiple MCOs fund services for different members in a single program but apply different expectations around quality, and when MCOs and providers must comply with different initiatives by DHS, cost goes up with no correlation to quality. The lack of any reference to the role of DQA in quality oversight suggests that the 2021 Draft is an overlay by DMS on existing initiatives, for services funded by Medicaid Managed Care. It would be helpful to get DMS's perspective on how the various rules, initiatives and pilots will converge to support a unified view of quality in Long-Term Care settings supported under Family Care. Recommendation #5: Create a Pilot for a Medical Home that Would Integrate Acute Care and Long-Term Care for a Targeted I/DD population with Complex Medical Needs. The 2021 Draft reflects the regulatory divide in Medicaid Managed Care in Wisconsin, between the world of Acute Care and the world of Long-Term Care. DMS must map out parallel but separate quality improvement road maps throughout the document, for each category of care. We urge DHS to continue to advocate forcefully for a system that allows a payor to look holistically at the cost of serving an individual with disabilities in the community, both for Long- Term Care and Acute Care. At the end of the day, the same group of people will be the beneficiaries of quality improvement efforts launched under Acute Care and Long-Term Care. Integration of the two service types would offer significant improvements in the quality of life for people with disabilities, at lower cost. We can cite two discrete subsets of Family Care clients we serve, who would see immediate benefit from an integrated approach. First are those individuals with I/DD

	who present with high levels of physical and cognitive challenges. Family Care enables these members to live in the community, rather than a more restrictive setting such as an institution or nursing home. This is a positive result and enhances quality of life. Yet these individuals continue to have chronic lifelong medical needs. Providers must exercise a great deal of care to ensure that individuals who show symptoms are promptly referred for treatment by an acute care provider or at the hospital Emergency Department. For some, visits can be so numerous as to interfere with quality of life for the clients, disrupt staffing, and increase overall cost. But because different payors are responsible for payments for Acute Care and Long-Term Care, no single entity is responsible for looking "over the fence" to examine the total cost of care, and to develop a treatment framework that allows for more frequent onsite preventive care visits. A second example can be found in the services we provide for Family Care members with Prader-Willi Syndrome (PWS). PWS is a complex genetic, chronic, life-threatening disorder. People with PWS experience a wide variety of medical challenges throughout their lifetime. One study reports they incur Medicaid costs for medical care of $40,868 per year, which is 7.7 times the average cost for people without PWS.3 3 Shoffstall, et al., "The High Direct Medical Costs of Prader-Willi Syndrome," The Journal of Pediatrics, August 2016, pp. 137-43. Those with PWS require ready access to medical professionals who have expertise in this rare disorder. For example, individuals with PWS tend to have lower metabolic body temperature, so what would be a normal temperature for a typical Family Care member, if present in someone with PWS, could signal a fever caused by an infection. Each aspect of the Triple Aim-health outcomes, patient experience, and cost effectiveness-are all enhanced when providers of long-term care, acute and primary health services share expertise in PWS and collaborate to assure a seamless approach. The 2021 Strategy cites examples of medical homes that DHS has already authorized to support targeted populations. We recommend consideration of a similar medical home pilot project, that would identify a subset of the Family Care population and put some limited initiatives and measurements in place to demonstrate the benefits of integrated care. Conclusion We appreciate the ongoing efforts of DMS to enhance the quality of care for the most vulnerable citizens of the State of Wisconsin. MyPath welcomes the opportunity to participate in further dialogue.
13	My opinions to the Managed Care program are based solely on long term care for seniors and adults with developmental disabilities. In my opinion, before things like “pay for performance” initiatives are put in place for providers; the pay given to all providers needs to be addressed and increased. Family Care is a flawed and broken system in need of a major overhaul. It incentivizes providing the highest level or care to the lowest bidder and rewards MCOs for their service by affording their top level management with 6 figure salaries and benefits. This is morally wrong and should be illegal given their nonprofit status. Furthermore; the program currently given very little power to DHS to

	actually oversee these MCOs. The program duplicates services that many of us already provide and actually create additional work for decreased reimbursement for our teams. I applaud the idea of Family Care and am happy Medicaid is here, but a the rates providers are being reimbursed; this system will fail and you will cause facilities to close and members to not receive the care and supervision they need. I have written to DHS, the Governor's office, legislators and anyone else who will listen but this system needs to be fixed and long term care providers need to be allowed in the process and not just DHS and the MCOs.
14	It was recently that a number of Lakeland members are no longer provided transportation services. This has created a very detrimental concern for the residents that receive state funding. Due to availability and cost of transportation, members will have less say in when and how they get to appointments. With this decision, the buildings that these residents are in are being forced to provide more staffing, van/bus cost, or bills from outside vendors for services because the building itself does not have 24/7 transportation services. Not all areas are equipped with the ability to have in house Dr visits, and even if that is set up, that is not giving state funded residents their choice in provider. It has put much more overhead on the buildings with state funded residents and it is not financially sound for AL's without a bus/driver to accept new clients. I feel, as well as others I have talked to in the community, that the transportation cost is affecting everyone and that the resident choice we all want to promote, is being taken away d/t resources. Thank you for your time and willingness to listen.
15	I am a Family Care provider in Milwaukee county. We have around 60 members in three assisted living CBRFs all located in Milwaukee. We specialize in the mentally ill. This is an extremely complicated program with many moving parts. I'm not sure how many people understand the full stack of interactions from federal down to the member. In the hopes of making an impactful comment, I will try to keep this email succinct and focused on the aspects of Medicaid that are closest to me. I will also try to keep my thoughts on possible solutions limited. I can accurately identify problems - coming up with good solutions that work in the full Medicaid stack is much more difficult. As a provider, here are the largest problems: <u>Rates</u> The current rate determination method for providers rewards strong negotiators, inefficiency, and punishes the members. The average small provider is not equipped to negotiate with a large MCO to get better rates. We are not allowed to collectively negotiate. What happens when rates are effectively cut year over year due to inflation and rising costs of employment? That money has to be made up somewhere. Members suffer for that cost. My rate with My Choice Family Care has increased by less than 4% in the past 10 years. How much have costs and inflation gone up since then? When I attempted to negotiate with them, they would not let me bill during our "negotiation" period and they suspended all referrals - directly breaking our contract with

	no repercussions. This is what they do to a mid-sized provider. What do they do to smaller providers? My only option was to try to move members over to another MCO that provided better rates. If the members don't want to change MCOs, they would have to find a different place to live. The rate determination by the MCO is arbitrary and inaccurate. They, theoretically, pay more if your costs are higher. How do they determine if your costs are higher? I don't know. That's what they tell me and there's no way to check their work. One factor is your self reported budget. Should you be reimbursed more if your business is inefficient and costs more to run - with self reported numbers? For me, this system works well. I am financially savvy and have networked enough to receive favorable rates. Smaller providers are punished. Should rate reimbursement be structured in a manner that favors the best negotiators and businessmen? Or should it factor in quality of care somewhere? <u>Services</u> The services that a provider is expected to cover vs the MCO have been continuing to increase, without increases in reimbursement. Rather than increases in efficiency, this leads to decreases in services. Providers are contractually obligated to cover the cost of all transportation for all members to any destination. I asked, "if a member wants to visit their sister 3 hours away every day, we must provide that transportation and cover that cost?" The answer is yes. If a member wants to go to a day program 5x a week across town, not only am I now obligated to provide that transportation, my overall daily rate is REDUCED for them going to the day program. With the new "Member Leave of Absence" rate (implemented 2/2021, which I will address further below), if the member is out of the building for 24 hours, I cannot bill for care and services. If the member wants to go be with their family for Christmas, I'm paid 20% of my typical daily rate. Every day the member is in the hospital, my rate is 20% of the typical rate. As a provider, what does all of this incentivize? It incentivizes the provider to keep people in the building at all costs. To keep a member out of the hospital, is the provider going to make sure they are healthy? Or are they going to not send them to the hospital when they should be going? Any extra service for the member or anything to improve their quality of life comes directly out of the provider's already diminishing bottom line. This incentivizes them to provide the bare minimum. <u>Member Leave of Absence</u>

	Prior to 2/2021, providers under My Choice Family Care billed for two services - Care & Services and Room & Board. Room & Board is contractually and legally paid by the member and to be paid to the provider. One of the methods for determining the Room & Board rate is the HUD rate for the county. This is the method My Choice Family Care used. The HUD rate in Milwaukee county increased in 2021. Members began paying about an extra $8 a day for Room & Board. Rather than pass this increase on to the providers, My Choice Family Care did away with the Room & Board rate entirely. They now only have a Care & Services rate and a new Member Leave of Absence rate. The new Care & Services rate is equal to the old Care & Services + old Room & Board rate. For illustrative purposes: Prior C&S: $80 Prior R&B: $20 Prior Total: $100 New C&S: $100 New R&B: $0 New Total: $100 What actually happened: C&S: $72 R&B: (increased by $8) $28 Total: $100 The MCO reduced their Care & Services rate and absorbed the increase from the members. Now, when members went to the hospital, providers could bill nothing. There was enough push back from providers that they created a new category of rate - the Member Leave of Absence. The Member Leave of Absence rate is billed when the member is out of the building for 24 hours for ANY reason. This is a significant rate cut relative to prior 2/2021 when Care & Services could not be billed only if the member was being provided care somewhere else (hospital, rehab). Summary Rates are effectively being cut, year over year. Services and quality of care is incentivized to be worse. The MCO continues to bloat with redundancies and inefficiencies. Their increased costs are passed on to the Providers and Members. We

	tighten our belts every year while the MCOs grow with no increases in quality or standards of care and no accountability. This email is already quite long. I can elaborate further on any of these topics and I have thoughts on many more. As I said earlier, identifying the problems is the easy part. Effective solutions are difficult.
16	Please find attached Inclusa, Inc.'s public comments regarding the Wisconsin Medicaid Managed Care Quality Strategy. We appreciate the opportunity to provide comment. Thank you. Best, Mark On behalf of Inclusa, Inc., we would like to thank the Department of Health Services (DHS) for the extensive efforts and collaboration to develop and implement innovative Medicaid programs across the state. Inclusa appreciates the opportunity to provide public comment on the "Proposed 2021 Managed Care Quality Strategy" (Plan) dated April 22, 2021. Inclusa is a Managed Care Organization with over 20 years of experience in delivering the Family Care Program. Currently, Inclusa is certified to provide the Family Care program in 68 Wisconsin Counties, serving 15,200 members, and contracting with over 6,000 services providers. Over those 20 years, Inclusa has provided high quality long-term care services. We are very proud that Family Care is now fully implemented and available statewide, making Wisconsin one of the first states in the nation to end waiting lists for three populations of adults who need long-term care. We are committed to working with the Division of Medicaid Services (DMS) to continuously improve member outcomes through the delivery of high-quality care while identifying and implementing changes that will improve the quality of life for participants. We look forward to working collaboratively with DMS to develop a progressive vision for the future of long-term care in Wisconsin. **Inclusa has several over-arching comments on the proposed quality strategy.** • DMS should develop a long-term strategy that supports transition to consistent statewide measures that align with a consistent set of national measures. The plan currently focuses on using CAHPS for acute/primary, while utilizing National Core Indicators (NCI) for long-term care programs. The differences in measures will lead to fragmentation of quality measures as Medicaid programs in Wisconsin continue to move towards Aligned Care models. • DMS is encouraged to be cautious with the approach of using available data metrics to define quality measures and strategy, versus defining quality measures and strategies that will then lead to building out key data metrics. Essentially, being careful to ensure the approach is focused on measuring what we value rather than inadvertently valuing what we can measure. • If DHS opts to use National Core Indicators (NCI), Inclusa agrees with using established measures and with not setting targets based on national averages. However, it

is not clear how formalized targets will actually be set. We request the opportunity to be involved with DMS in the work of establishing formalized targets for Family Care.

- In many areas of the Plan there are references to utilizing External Quality Reviews (EQR) to measure Quality Objectives. EQRs focus is on CMS performance measures which are tied to quality assurance measures and not necessarily focused on quality improvement indicators. We recommend the process of measuring Quality Objectives be separate from quality assurance measures and incorporated into a process that emphasizes continuous quality improvement.

Inclusa offers the following specific comments on the draft Medicaid Managed Care Quality Strategy.

Long-Term Care

Goal 1: Service Delivery and Effectiveness

Provide services and supports in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes.

- Change current objective, "Increase the percentage of people who know whom to ask if they want to change something about their services." This could easily be changed to a more meaningful measure that has been captured in the Member Satisfaction Survey for several years, "Q11: How well do the supports and services you receive meet your needs?" with potentially the addition of "help you achieve your desired outcomes." This would be a direct reflection of service delivery and effectiveness. There are also several NCI questions much more specific to service delivery and effectiveness. For example, "% who report having access to an adequate array of services and supports."

Goal 2: Person-Centered Planning and Coordination

Focus assessment, planning, and coordination of services and supports on the individual's goals, needs, preferences, and values.

- Both objectives in this area are dependent upon the EQR completed by Metastar. Inclusa is not opposed to using the measures, but when there are changes to the criteria to achieve a "met" rating, there will likely be an unexplained/unexpected decline in performance across the Family Care program.
- Suggest establishing a measure that captures the level of involvement the member had during Person-Centered Planning; there are questions on the Member Satisfaction Survey that may be more appropriate.

Goal 3: Choice and Control

Empower individuals to, on their own or with support, make life choices, choose their services and supports, and control how those services and supports are delivered.

- The current objective, "Increase the percentage of people who can choose their services" is not an effective measure of choice and control. A plan that is person-centered will allow an individual some choice regarding their services. A better measure here would be the percentage of people exercising their right to self-determination by directing the plan; therefore, a measure of self-direction or self-determination would be optimal. Even some of the questions on the Member Satisfaction Survey would be better. For example, "How involved are you in making decisions about what is included in your care plan?" or "How much does your care plan include and address the things that are

	most important to you?" These would be metrics that DMS already has a baseline for. There are NCI questions that may be more reflective of choice and control. In addition, there could potentially be some measures related to HCBS settings rule that could be also incorporated; notably, the requirement to offer choice of setting which includes at least one non-disability-specific setting. **Goal 4: Equity** Provide equitable access to services and supports. • Recommend including an objective specific to access to LTC supports and services for tribal members. **Community Engagement** **Goal 5: Community Inclusion** Provide the opportunity for people to be integrated into their communities and socially connected, in accordance with their personal preferences. • We would suggest the addition of NCI questions. For example, "The percentage of people who report doing things in their communities that they like to do, as often as they want". In addition to "% employed who work in non-workshop settings." **Caregiver Support and Workforce** **Goal 6: Caregiver Support** Offer financial, emotional, and technical support for family caregivers or natural supports of individuals who use HCBS. • Caregiver Support, "% of adults living with spouse and/or family receiving unpaid care who also receive respite (from WI LTC Scorecard). If this is an objective, it should be communicated more broadly to have more of an impact. • Also recommend a measurement reflecting on the % of respite offered and if respite occurred in a preferred setting being included within the objective. **Goal 7: System Performance and Accountability** Ensure the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. • System Performance and Accountability. It is important to distinguish that care management is considered a member service cost; while it is more important to some members than others, it is critical to the supports members receive and is required per federal regulation. **Goal 8: Workforce** Ensure the HCBS workforce is adequate, available, and appropriate to serve the needs of people who use HCBS. • This measure, "increase % of people whose support staff treat them with respect" does not seem to be a good indicator of the goal. The CAHPS survey has some great measures of staff responsiveness & availability that we would recommend including. NCI has "% of people who report that their staff come and leave when they are supposed to" which is another appropriate alternative. Additionally, questions used to measure

	certain HCBS Settings Rule standards may also be applicable here, including questions to evaluate compliance with requirement to ensure a member's rights of privacy, dignity, respect and freedom from coercion and restraint. • Recommend reviewing the recommendations from the Governor's Taskforce on caregiving and include an objective related to recruitment and retention of Direct Support Professionals and/or related to access to direct support professional training. • Inclusa suggests including an objective related to having a culturally competent workforce. **Goal 9: Human and Legal Rights** Promote and protect the human and legal rights of individuals who use HCBS. • Results specific to the current measure, "increase % of people who feel safe around their support staff" are already quite high and do not leave much room for improvement. Inclusa would recommend leveraging other measures available in in AQR/CMR data – specific to member rights and/or Notice of Action (an area with room for improvement). Another effective measure could be found in looking at the % of members with rights limitations or restrictive measures (either reducing the percentage of people who have them or increasing percentage where process is appropriately followed). There may also a variety of measures in NCI data that may be preferable and offer opportunities for improvement. • Inclusa suggests including a measurement that looks at the # or % of individuals with full legal guardianship in place, using limited guardianship, or have supported decision making agreements enacted. **Goal 10: Consumer Leadership in System Development** Support individuals who use HCBS to actively participate in the design, implementation, and evaluation of the system at all levels. • Consumer Leadership in System Development, "Increase % of people who participate in Member Satisfaction Survey." Inclusa is unsure if this is intended to be the response rate for the • DHS administered survey or the actual percentage of program participants for whom a survey was received. Inclusa is not seeing this as an effective measure of involvement in system development. Inclusa suggests DMS look for a measure specific to the state LTC Advisory Council such as % of the committee comprised of members/IRIS participants. DMS might also consider a measure specific to composition of the MCO Boards of Directors or member participation in Member Advisory Committees of MCOs. • Inclusa also sees measuring the number of listening sessions being held as an important indicator of involvement in systems development. **Well-Being** **Goal 11: Holistic Health and Functioning** Assess and support all dimensions of holistic health. • Holistic Health and Functioning; Increase Vaccination Rates AND decrease % of people whose self-reported health is poor. DMS has some concrete measures of health and functioning on the LTCFS. Inclusa recommends DMS look at % of members or

	participants who maintain functional abilities from one year to the next. DMS could also use some of the Medicaid measures that are being used for HMOs. Also, DMS might consider having Covid immunization included instead of the immunizations that have been measured for the previous years. In conclusion, we appreciate the ongoing efforts of DHS to advance quality improvement efforts across the Medicaid Programs and the continued aspirations for everyone to be living their best life. Inclusa welcomes the opportunity to participate in further dialogue around the quality strategies and our comments.
17	Attached please find Disability Rights Wisconsin comments to the Managed Care Quality Strategy. Please contact me if you have any questions. Thank you for the opportunity to comment on the 2021 Medicaid Managed Care Quality Strategy prior to its submission to CMS. DRW is the Protection and Advocacy system for people with disabilities in Wisconsin and is the home of the Family Care and IRIS Ombudsman program (FCIOP), which is the individual advocacy program for Family Care members and IRIS participants ages 18-59. We are also the home to the SSI Managed Care External Advocacy Program. Because of time constraints we will largely be confining our comments to the long term care provisions of the proposed strategy. Please note that the fact that we may not have commented on a part of the Strategy should not be interpreted as approval. It simply reflects the reality that this is a dense and complex document and DRW does not have the resources to study and critique it in detail. We will say, however, that the strategy appears comprehensive and, at least with respect to the long term care component, has the potential to assess for several of the aspects of a long term care system that are of most importance to people with disabilities who are experiencing Family Care and Family Care Partnership. Two areas where we do not see specific quality indicators relates to specialized providers for people with intense behavioral support needs and crisis services, typically necessary for that same population. Pay for Performance The proposal's descriptions of "pay for performance" are confusing. On page 15 of the proposal the system is described thus: "The Pay for Performance (P4P) initiative focuses on improving measurable quality of care for Medicaid members. Its current scope includes HMOs, with applicable capitation withholds that can be earned back by HMOs based on their performance relative to quality targets for selected measures applicable to them." The description is entirely punitive, meaning HMOs can lose money for deficient performance, but receive no fiscal incentive to exceed performance standards. In other parts of the document, however, P4P includes incentive payments. For example, on page 24, in the description of P4P, it says: "DMS currently implements three Pay for Performance initiatives for the Family Care and Family Care Partnership programs. Pay for Performance initiatives involve withhold and incentive arrangements used to encourage PIHPs to drive improvements in prioritized program areas." This indicates

that P4P may be implemented differently in long term managed care and includes incentive payments to meet or exceed quality goals. The actual definition of P4P is this: "Pay-for-performance is a term that describes payment systems that offer financial rewards to providers who achieve, improve, or exceed their performance on specified quality and cost measures, as well as other benchmarks." (p. 71). This definition would seem not to include a punitive financial component.

We endorse a system that includes incentive payments, either as a means of elevating performance significantly or exceeding performance standards set by DHS. Punitive P4P (assuming they are even permitted) should only be used when no measurable progress towards standards is made or the entity falls further behind the starting benchmarks. In a capitated rate system, withholding capitation payments negatively affects the entire HMO/MCO membership. They should be avoided except in circumstances where there is clearly deficient performance.

Finally, it does not appear to us that the document contains any specific detail about how and when P4P will result in withholding of capitation rates or, conversely, when it will result in incentive payments. We assume that is because this is a "strategy" document, rather than an implementation document. We note that the existing P4P projects relate to member engagement in competitive integrated employment, quality of "Assisted Living Communities," and member satisfaction. These are certainly areas of critical importance to members. It is our expectation that stakeholders will have input into the development of any additional specific P4P projects, regardless of whether they are punitive or incentive.

Long Term Care Quality Indicators

The twenty-six LTC areas selected for the quality measurement represent a good cross section of objective and subjective areas of performance by Family Care MCOs. From our perspective, at least fifteen of the measures relate specifically to the ongoing member experience. To the Department's credit, they include a number of areas where the baseline measure is not strong. It is a positive sign that DHS is focusing on its weak areas of performance and on areas that are more subjective.

Several of the baseline data figures indicate serious issues with the quality of the long term care programs. For example, satisfaction with the assessment process is quite high (97.1% for FC and 96.7% for FCP). But satisfaction with the comprehensiveness of the member centered plan resulting from the assessment is quite low-with a with a 29-point difference for the Family Care program (only 68.1% believe their MCP is comprehensive). This result is consistent with the anecdotal experience DRW has had with the program. As the focus of the MCP process has moved away from the expansive so-called "personal experience outcomes" to the far more limited "long term care outcomes," member plans have addressed fewer aspects of a member's life that matter most to them. This is also reflected in the baseline data for the questions related to specific life activities that keep people connected with their communities. So, for example, the percentages of people who report that they have a way to get to places they want to go outside the home (NCI 56 and NCI-AD-22) are quite low, at 71% and 68%

respectively. And the percentages of people who report they are able to participate and be as active in the community as they would like (NCI66 and NCI-AD-1) are even worse at 33% and 46%.

These and other baseline measures indicate that Family Care and FCP have much room for improvement. These figures simply cannot remain that low. Our feeling is that these numbers are the direct and foreseeable result of the shift away from addressing personal experience outcomes in the MCP process. These numbers must get significantly better and the only way to do it is to return the focus in the planning process to more than just the basics of health and safety. When Family Care was created "personal experience outcomes" and "long term care outcomes" were one and the same. In the Family Care regulation they still are (see § DHS 10.44). But when the member and the MCO sit down together to do "resource allocation" they are not. The personal experience outcomes are, frankly, given short shrift, as painfully evidenced by these numbers.

So, again, we are pleased to see that DHS is taking on the difficult questions as it considers whether its long term care programs are meeting the objectives of a home and community based services waiver program. We look forward to seeing improvement in the numbers over the next three years as a result of a reorientation of the program on the aspects of life that matter most to people with disabilities.

Absent Measures

As we indicated at the outset, the areas of Family Care that are not addressed by the 26 quality measures relate to people with high needs. Mostly these are people with severe intellectual disability or traumatic brain injury. These members require specialized services and are the most in need of crisis services. They are also, in many cases, among the highest cost members, even when receiving inadequate or barely adequate services. As we have informed the Department, the network of providers trained and staffed to address the needs of these members is thin. And the absence of crisis services to serve people when behaviors become difficult to manage is an acute problem. We have provided the Department with multiple examples of high-needs clients being housed in manifestly inappropriate in-patient settings, being restrained, and being bounced between inappropriate and poorly prepared community placements.

The managed care model is designed for the average member. Any managed care model is going to have difficulty serving (or be reluctant to serve) those with the highest needs, since those are its most expensive members. Hence the "cherry-picking" problem in the managed care model. We understand that the retort to this is that the capitated rate accounts for this because it is a blend of the costliest and least expensive members. We are not actuaries, but our practical experience tells us that for whatever reason, the highest needs people are having the most difficulty in Family Care.

This issue falls within the broader category "network adequacy," which is not addressed by these quality measures, but is, ostensibly addressed elsewhere in the Strategy. We understand that the Department is beginning to acknowledge this problem. As its understanding and appreciation of the problem increase, we would hope to see some related measure added to the quality measures part of the Strategy.

18	**Health Disparities and Data Collection** 1. Demographic data collected, as outlined on page 52 of the Quality Strategy, to better assess health disparities should go further to include: gender identity, sexual orientation, special healthcare needs beyond disability status, geographic area, and socioeconomic status. Rationale: While race, ethnicity, age, sex, primary language, and disability status are all important factors in demographic data collection, they cover only a piece of the population and neglect health disparities among the LGBTQ+ community, persons of varying socioeconomic status, and persons with special healthcare needs who may not qualify (or have not yet qualified) for a disability designation. All of these demographic data points are outlined by the Office of Disease Prevention and Health Promotion to be key factors in determining where disparities exist. Additionally, in order to determine what communities, and even neighborhood are undeserved and may need further assistance, HMOs should be looking at where members live. 2. To promote health equity and reduce health disparities, as a part of their Quality Assurance beginning on page 48, HMOs should prioritize continuity of member coverage *and* care by tracking and anticipating certain health coverage transitions to reduce churn. Helping members anticipate change events (birthdates, renewals etc.) and help avoid certain disruptive changes with proactive help will leave fewer members without coverage or lost in the transition to a commercial or Marketplace plan. Promoting continuity of care, coverage and equity includes tracking demographic and eligibility information such as: age, medical condition, insurance coverage, vaccination record, mental/behavioral health issues, and potential language barriers. Rationale: Certain member churn can be avoided. Churn adversely affects continuity of care in patients which can lead to poorer health outcomes. By tracking healthcare coverage, eligibility, and data related to transitions in coverage, HMOs can proactively work to prevent churn, improving continuity of care and access to care. This has the effect of reducing health disparities and improving health equity through maintaining Medicaid eligibility for certain folks while assisting others to ne or emerging coverage options. 3. The Acute and Primary Care Performance Measures on pages 13 to 15 should include measures and goals regards more facets of EPSDT (HealthCheck), HealthCheck Other Services, SSI, Long Term Support Waiver, and others. Examples of areas that should have related measures and goals include referrals to specialists, whether those referrals were utilized, outreach to eligible families, health outcomes, transition planning and care, or approvals and denials for services. Rationale: Ensuring that children and youth are receiving the appropriate number of screenings is important but presents only one facet of the EPSDT (HealthCheck) program. In order to evaluate the health of the system as a whole HMOs should report on other critical aspects of the care a child might receive through the program. By

	evaluating these other areas, we promote health equity by identifying underserved populations and it helps to give a picture of what services are being utilized by what groups and what aren't so as to respond and ensure all children and youth are receiving the services to which they are entitled. Referral data, and how often referrals are utilized should be kept to determine what population need additional follow-up. Furthermore, HMOs should maintain consistent and uniform records and billing information across all MMC so as to accurately evaluate service utilization. **Accountability** 1. HMO self-assessment for ongoing education and cultural competence identified on page 36 should either (1) not be a self-assessment but instead should be assessed by the state or a third party, or (2) the assessment process and results should be reported to the Division of Medicaid Services and made public. Rationale: Cultural and language competence is essential for reducing health disparities and promoting health equity. In order to both promote transparency and accountability, HMOs should have some oversight in their assessment process to ensure it meets standards of best practice. 2. The Division of Medicaid Services should include transparent and direct enforcement mechanisms for the HMO contract. For examples, HMOs failing to report specific metrics about meeting the 80% target threshold for HealthCheck Screenings should be fined per their contract. Rationale: There are numerous enforcement mechanisms within the HMO contract of which are scarcely, if ever, carried out including fines. As one example, there is a flat $10,000 fine for any HMO missing the 80% screening target for HealthCheck that, to our knowledge, has never been used despite missing that target state-wide for years. Federal and state Medicaid statutes, as well as federal regulations, require that the State carry out the mandated responsibilities of providing EPSDT services to individuals under the age of 21. The stated goal of the program is to proactively catch health problems before becoming more severe or chronic. The consequences of inaction include poor health outcomes for children and penalties for not supplying mandated services should reflect the gravity of not following through with the contract and state and federal law. Further, any fines collected should be directed to promote ongoing education, outreach, and client assistance programs. **Outreach/Engagement** 1. Promote equity and reduce disparities by developing, promoting, providing health benefits management services (AKA Access Management) for customer prioritizing at risk youth, families, and other customers. Rationale: Federal Medicaid law requires that the State (in this case through HMOs) provide certain health benefits management services (AKA Access Management). Benefits management services seek to remove the burden from patients and their families of self-navigating many healthcare service and coverage options with little expert help.

	Properly trained and supported advocates at HMOs can better help patients and their families pro-actively problem solve to provide essential links with necessary services and coordinate with providers. 2. Strengthen customer dispute and problem resolution services. Revise location and structure of HMO Ombudsman contract/services to an organization that has a mission of such services to consumers. O promote these services, create external advocacy services and support similar to SSI managed care services. Identify initial training program and continuing education process for Ombuds staff, and create a transparent data reporting structure to measure services, scope and outcomes. Rationale: A key aspect to providing effective healthcare coverage and facilitating services is being able to effectively respond to problems that arise and resolve them quickly and amicably. By providing more robust training and by reporting cases and outcomes HMOs are more accountable to ensuring members needs are met. 3. HMOs should provide measurable outreach and education of members to ensure they are aware and can secure needed services. Rationale: Members cannot take advantage of services to which they are entitled if they are not aware that they exist and in some instances without expert help in obtaining their services. HMOs can improve health equity and reduce health disparities by reaching out to members who might otherwise not be aware of services available. Additionally, many members have troubles accessing services and making appointments and HMO help in obtaining services would greatly improve follow-up and access to necessary medical services. **HealthCheck (EPSDT)** 1. Improve data transparency for HealthCheck: Data collected for the HealthCheck (EPSDT) CMS 416 data report should include additional information that help define the scope of services provided to eligible children/youth in Wisconsin. Rationale: The current data disclosed through the CMS 416 report regarding the health of Wisconsin's EPSDT program (HealthCheck) is extremely minimal and does not provide a good window into the effectiveness of the program. HMOs should track more data points such as referral or case management utilization in order to promote data transparency and provide a better evaluation of EPSDT. 2. HMOs are required by law to reach out to families to educate them on services available under HealthCheck as well as manage their coverage. Rationale: To conform with federal law, specifically 42 U.S.C. §1396a(43)(A)-(B), as it relates to EPSDT (HealthCheck) HMO responsibilities should include education, outreach and coverage management as part of the State's responsibilities (and by extension the responsibility of managed care organizations). A HealthCheck requirement for HMO organizations is to "provide outreach and basic case management services to inform and assist members in obtaining HealthCheck services," per the ForwardHealth handbook (topic #2431).

	3. HMOs are also required by law to notify families and arrange for corrective treatment identified during screening services for children and youth in HealthCheck Rationale: 42 U.S.C. §1396a(43)(A) mandates that all persons under the age of 21 are notified of services of which they are available under HealthCheck including referrals and any other medically necessary services that would be covered by Federal Medicaid. 42 U.S.C. §1396a(43)(C) mandates that the State (in this case being delegated to the HMO) "provide for arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services. 4. Pursuant to federal law, MCOs must make residential treatment services available for children with behavioral and psychiatric health concerns. Rationale: The inequitable treatment of behavioral and mental health conditions is a major health disparity that ought to be addressed. While residential treatment is currently covered under Wisconsin EPSDT (HealthCheck), the benefit is not made available in practice as the onus is on the family to locate and get a residential treatment facility enrolled in Medicaid and convince them to accept their child. Federal EPSDT statutes require treatment for all medically necessary services be made available and this includes mental and behavioral health services. 5. Wisconsin Medicaid provides two separate lists of over the counter (OTC) medications that are covered for members. In order for members to use this benefit effectively, MCO's should provide specific outreach messaging and fact sheets that describe the benefit and list the covered OTC medications for adults and for children through HealthCheck "Other Services".
19	ViiV Healthcare Company (ViiV), wishes to offer the following comments to the Wisconsin Department of Health Services (DHS) on its 2021 Medicaid Managed Care Quality Strategy.1 ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in human immunodeficiency virus (HIV) treatment and prevention to support the needs of people living with HIV (PLWH). From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment. As an exclusive manufacturer of HIV medicines, ViiV is proud of the scientific advances in the treatment of this disease. These advances have transformed HIV from a terminal illness to a manageable chronic condition. Effective HIV treatment can help people with HIV to live longer, healthier lives, and has been shown to reduce HIV-related morbidity and mortality at all stages of HIV infection.2,3 Furthermore, effective HIV treatment can also prevent the transmission of the disease.4

HIV and Medicaid 2

In 2018, there were 6,331 people living with HIV in Wisconsin.5 Medicaid is an essential source of access to medical care and antiretroviral treatment (ART) drug coverage for people with HIV. More than 42 percent of people with HIV who are engaged in medical care have incomes at or below the federal poverty level.6 This medical care and drug treatment not only preserves the health and wellness of people with HIV and improves health outcomes, but it also prevents new HIV transmissions.

We applaud Wisconsin for its history of innovative care in Medicaid through waivers such the HIV/AIDS Health Home7 and the HIV Affinity Group collaborative project between Medicaid and the state HIV program. The HIV/AIDS Health Home is a BadgerCare Plus HMO. This program works through Vivent Health to provide comprehensive care at locations in Milwaukee, Kenosha, Brown, and Dane counties, and also includes home and community-based services.8 We appreciate that in this quality plan, the state intends for the HIV/AIDS Health Home to continue to focus on quality improvement, by requiring collection of data and quality measures to set baselines and provide measures for program performance.9

Measuring Quality HIV Care in Medicaid:
Although the state provides a rationale for the required reporting measures included at this time, in the Quality Measure Matrix,10 we note that the state is reporting on measuring such as chlamydia screening, but no measures related to HIV quality care. Optimal outcomes for people with HIV can only occur if systems are measured and are able to benchmark their performance against the current standard of HIV care. The use of HIV-related quality measures will promote standards of health care coverage that support adherence to current HIV clinical and federal guidelines.11

When a person with HIV receives and maintains effective HIV treatment and receives quality medical care, they can reach viral suppression. Viral suppression means that the virus has been reduced to an undetectable level in the body with standard tests.12 Viral suppression results in reduced mortality and morbidity and leads to fewer costly medical interventions.13

Viral suppression also helps to prevent new transmissions of the virus. When successful treatment with an antiretroviral regimen results in virologic suppression, secondary HIV transmission to others is effectively eliminated. In studies sponsored by the National Institutes of Health (NIH), investigators have shown that when treating the HIV-positive partner with antiretroviral therapy, there were no linked infections observed when the HIV+ partner's HIV viral load was below the limit of detection.14 The National Institute of Allergy and Infectious Diseases (NIAID) supported research that demonstrated when people with HIV achieve and maintain viral suppression, there is no risk scientifically of transmitting HIV to their HIV-negative sexual partner.15 Multiple subsequent studies also showed that people with HIV on ART who had undetectable HIV levels in their blood, had essentially no risk of passing the virus on to their HIV-negative partners sexually.16, 17, 18 As a result, the Centers for Disease Control and Prevention (CDC)

	estimates viral suppression effectiveness in preventing HIV transmission at 100 percent.19 Reduced transmissions not only improve public health, but also save money. Preventing new transmissions offers a substantial fiscal benefit to the state. In studies sponsored by the NIH, investigators have shown that when treating the HIV-positive partner with antiretroviral therapy,20 there were no linked infections observed when the infected partner's HIV viral load was below the limit of detection. It is estimated people with HIV who are not retained in medical care may transmit the virus to an average of 5.3 additional people per 100-person years.21 A recent study of commercially insured people with HIV compared to individuals without HIV found that mean all-cause costs were almost seven times higher in those with HIV, culminating in an average discounted incremental cost of $850,557 in cumulative costs from ages 25-69.22 Successful treatment with an antiretroviral regimen results in virologic suppression and virtually eliminates secondary HIV transmission to others. As a result, it is possible to extrapolate that successful HIV treatment and medical care of each infected patient may save the system up to $4.5 million by preventing further transmission to others. These savings can only occur if people with HIV have access to medical care, receive treatment, and remain adherent to their prescribed therapy. The "HIV Viral Load Suppression (VLS)"23 measure is the gold standard in HIV quality, as it signifies that a patient has reached the goal of HIV treatment, which is viral suppression. Since Medicaid is the largest source of health care coverage for people with HIV, it is imperative for Medicaid programs to prioritize HIV care and viral load suppression by measuring and reporting VLS in order to align with the Ending the HIV Epidemic (EHE) strategies of rapid treatment and HIV transmission prevention.24 ViiV encourages the state to move towards reporting on the VLS outcome measure, both reporting at the plan-level and also reporting out the state level data to the Centers for Medicare and Medicaid Services (CMS) as part of the Medicaid Core Set. We further encourage the state to require the managed care plans to publicly report VLS rates by race, sexual orientation and gender identity. This will help to hold the health plans accountable for improvement in HIV care. Medicaid uses quality measures to assess care quality, assign provider accountability, and support performance improvement. Tracking and reporting HIV measures in the Medicaid Adult Core Set will help to ensure their future inclusion on the CMS Medicaid Scorecard.25, 26 The Scorecard compares outcome measures that are reported by at least twenty-five states. Several state Medicaid programs have linked HIV quality measures to managed care performance, thus incentivizing achievement of viral suppression for their people with HIV. For example, the New York State's Ending the Epidemic Plan recommends that HIV providers, facilities, and managed care plans report and monitor viral suppression rates and provide financial incentives for performance.27 Consequently, New York State's Department of Health requires managed care plans to report HIV-specific measures, including the VLS outcome measure, and awards financial incentives based on

	performance on these HIV measures.28 New York's managed care efforts have significantly improved viral suppression rates among Medicaid beneficiaries; by linking many people with HIV to care, managed care plans report that more than 40 percent of their Medicaid beneficiaries who were identified as unsuppressed, have now achieved viral suppression.29 Louisiana's Medicaid managed care program, Bayou Health, has included the VLS outcome measure in its contracts with MCPs. To further drive improvement, managed care plans have incorporated resources from the Louisiana Office of Public Health's (OPH) STD/HIV Program into disease management programs after the state added measures to their contracts. The managed care plans will continue to support the ambitious HIV care and treatment programs that have achieved 57 percent viral suppression among people with HIV in Louisiana.30 However, given the difficulty for some states in collecting and reporting VLS, "Retention in Care" measures for people with HIV could serve as a positive surrogate endpoint of high-quality HIV care.31 People with HIV who receive long-term clinical care are more likely to begin antiretroviral therapy and achieve viral suppression, dramatically lowering the risk of transmitting HIV to others.32,33,34 Because long-term HIV care is strongly associated with viral suppression and optimal health outcomes for people with HIV, the state could consider measuring retention in care, which includes adherence and medical visits frequency quality measures, as an initial step in HIV quality measure reporting, and moves towards the goals of VLS. 5 Another HIV measure, the Pharmacy Quality Alliance's (PQA) *Antiretroviral Proportions of Days Covered* adherence measure (PDC-ARV),35 could also facilitate an improvement in adherence to HIV medications, which is especially important in HIV due to the impact to people with HIV on their quality of life and life expectancy, but also in terms of lowering HIV transmission risk to others.36 Optimal outcomes for people with HIV can only occur if systems are measured and are able to benchmark their performance against the current standard of HIV care. The use of HIV-related quality measures will promote standards of health care coverage that support adherence to current HIV clinical and federal guidelines.37 **Health Equity** ViiV appreciates the state's efforts to address improving health equity and combatting health disparities as a way to improve health outcomes in Medicaid managed care populations through such strategies as establishing policy advisor positions focusing on health equity, and the creation of a DMS-wide Equity and Inclusion Committee, and a project to specifically look at health equity improvements for the HMO program.38 In 2020, the federal Department of Health and Human Services (DHHS) released The HIV National Strategic Plan (HIV Plan), which focuses efforts across government agencies to stop the HIV epidemic. The HIV Plan includes a focus on inequities and health disparities as they impact HIV prevention and care efforts. 39 The HIV plan notes,

	that "programs, practices, and policies affect communities of color and other populations that experience HIV disparities."40 The HIV Plan also prioritizes efforts to reduce disparities and improve HIV outcomes on 5 priority populations: 1) gay, bisexual, and other men who have sex with men (in particular Black, Latino, and American Indian/Alaska Native men), 2) Black women, 3) transgender women, 4) youth aged 13–24 years, and 5) people who inject drugs. 41 HIV continues to have a disproportionate impact on certain populations, particularly racial and ethnic minorities and gay and bisexual men.42 In 2018, there were 1,039,680 people living with HIV in the U.S., with 76.4 percent of people with HIV male and 40.6 percent black. Also in 2018, 81.0 percent of new HIV diagnosis were male, and 42.2 percent were black.43 As noted in the HIV Plan, "racial and ethnic minority groups are more likely to be uninsured compared to non-Hispanic whites, limiting their access to health care."44 This is one reason that Medicaid is so important to ending the HIV Epidemic. More than 42 percent of people with HIV who are engaged in medical care have incomes at or below the federal poverty level.45 6 Populations disproportionately affected by HIV are also often affected by stigma due to, among other things, their gender, sexual orientation, gender identity, race/ethnicity, drug use, or sex work. 46 Therefore, the CDC recommends that, "The perspectives and needs of LGBT individuals should be routinely considered in public health efforts to improve the overall health of every person and eliminate health disparities."47 Stigma is a significant concern in addressing the HIV epidemic.48. 49, 50 HIV stigma - the negative attitudes or beliefs around HIV disease - can lead to discrimination and prejudice from others, and even by healthcare providers.51 HIV stigma is often rooted in lack of information and awareness combined with outdated beliefs and scientific misconceptions about how HIV is transmitted and what it means to live with HIV today. According to the CDC, HIV stigma and discrimination can keep people from getting tested for HIV, learning their HIV status, accessing treatment, or staying in care. HIV stigma can also affect those at risk of HIV by discouraging them from seeking HIV prevention tools and testing.52 The importance of continuity of care for medically underserved patients, particularly people living with HIV or at risk for HIV, is significant. Patients retained in active medical care often have long-standing, trusting relationships with their medical provider, which is a key piece of the successful management of HIV. Some beneficiaries may forgo care entirely, rather than visit an unfamiliar provider without experience caring for stigmatized, disadvantaged or complex care populations. It is vital that healthcare providers for populations impacted by HIV and at-risk for HIV strive to provide care that is client-centered, respectful, culturally and linguistically appropriate, and inclusive. We encourage the state to ensure that your efforts to address health inequities in Medicaid managed care include both LGBTQ populations and racial assessments and interventions. For example, in the state's proposed MCO Satisfaction Survey, we applaud the state for proposing to include a question about how respectfully the care

team treats the patient. However, we encourage the state to ask specific questions related to racially, culturally and linguistically appropriate care, as well as care that is respectful of sexual orientation, sexual and gender identity. We further encourage the state to create a focus not just on polling patients, but on educating providers about populations that are disproportionately affected by HIV, including LGBTQ populations.

Providers in the state should be made aware of the HIV education and consultation options offered by the federal government. The Ryan White AIDS Education Training Centers (AETCs) are regional bodies which offer resources and program for provider education on HIV.53 DHS should advise network providers on the offerings of the AETCs. DHS could also, as part of the effort to address health inequities and stigma, require that all providers in the state fulfill a minimum amount of continuing medical education (CME) training on HIV as other states have done. For example, due to the high burden of HIV incidence, the District of Columbia requires licensed health professionals to complete at least ten percent of their continuing education in the public health priorities of the District, including HIV54 and LGBTQ cultural competency to help health care professionals to better understand the health challenges faced by these communities.55 This is especially important for those providers who treat only a few people with HIV, as studies show that HIV patients see better outcomes when treated by an experienced HIV provider.56

HIV & Social Determinants of Health

We appreciate the state's efforts to address Social Determinants of Health (SDOH) as a way to improve health outcomes in Medicaid managed care populations through such strategies as community referrals in care plan development and establishing policy advisor positions focusing on housing insecurity.57

The federal HIV Plan includes a focus to address factors that impact health for people with HIV including the social determinants of health (SDOH).58 People with HIV often face a variety of medical challenges that impede access to, engagement in, and adherence to HIV care and treatment. In 2020, the DHHS released The HIV National Strategic Plan (HIV Plan),59 includes a focus on the role of SDOH in ending the HIV epidemic. The HIV Plan notes that SDOH can represent a significant barrier to health care access, and states that: "Inequities in the social determinants of health are significant contributors to health disparities and highlight the need to focus not only on HIV prevention and care efforts, but also on how programs, practices, and policies affect communities of color and other populations that experience HIV disparities."60 ViiV offers the follow recommendations on SDOH:

a) Model SDOH on the Proven Interventions of the Ryan White Program

ViiV urges the state, in developing its goals and strategies around SDOH, to review and model elements of the Ryan White HIV/AIDS Program (RWHAP), that have proven to be effective in supporting optimal patient care and driving treatment success in HIV. The success of specific RWHAP interventions could help to inform the state's goals for SDOH efforts, and help to refine requirements for the managed care plans, and the program's data could also provide a basis for measuring outcomes of these interventions.

	The RWHAP over the last 30 years has developed a model of successfully addressing the complex needs of HIV/AIDS patients and producing unparalleled success in health and medical care among this population. The RWHAP provides services that demonstrated success in supporting the health and well-being of patients. These services offer best practice examples for how interventions focused on the social determinants of health can contribute to medical success. The RWHAP provides medical support services such as medical case management, medical transportation, and medical nutrition services, as well as oral health and dental care. The program also offers individual support services including food services, meal delivery, housing, transportation, legal services, linguistic services, case management, childcare, psychosocial and mental health services, rehabilitation and respite care, and substance abuse services. As a result of the program's services, in 2018, 87.1 8 percent of Ryan White HIV/AIDS Program clients were reported to be virally suppressed. This far exceeds the national viral suppression average of 62.7 percent at the time of this report.61 We urge the state to work with state Ryan White program officials to learn from the successes of the program, and the data the program has collected on its interventions, as a way to refine goals and best practices in addressing SDOH through targeted interventions. **b) Housing as an Example of SDOH Impact on HIV Treatment Success** We appreciate the state's efforts to address housing as a key SDOH, by establishing policy advisor positions focusing on housing.62 Access to stable housing can be a key intervention in stabilizing medical care for many vulnerable populations. The HIV Plan notes that housing instability or homelessness represents a significant barrier to health care access, and that people with HIV experiencing unstable housing or homelessness have lower rates of viral suppression, and therefore require services to support engagement in care and viral suppression.63 Homelessness and housing instability also remain obstacles to effective HIV treatment. A systematic literature review found that 94 percent of studies associated worse HIV medical care outcomes among those who were homeless, unstable, inadequately housed compared to "housed" people with HIV, and 93 percent found worse rates of adherence to antiretroviral treatment among those who were homeless or unstably housed.64 Of the 13 studies that examined emergency room (ER) and inpatient visits among people with HIV, all found higher rates of ER visit or inpatient stays among those who were homeless or unstably housed. 65 Additionally, among homeless people with AIDS who received supportive housing, there was an 80 percent reduction in mortality.66 This is not surprising given that people with HIV and stable housing are much more likely to access health services, attend primary care visits, receive ongoing care and receive care that meets clinical practical standards. According to the National AIDS Housing Coalition, "It is clear that housing improves health outcomes of those living with HIV disease and reduces the number of new HIV

infections. The end of HIV/AIDS critically depends on an end to poverty, stigma, housing instability, and homelessness."67

The Housing Opportunities for Persons with AIDS (HOPWA) program can also offer an example of how addressing the SDOH can have a significant impact on health care improvement in a population with a complex condition. The HOPWA program was created in 1992 to address the housing needs of people with HIV. We encourage the state to further consider the impact of homelessness on HIV care and treatment, and to work together with regional HOPWA program officials to seek coordination and share best practices. 9

Conclusion

Thank you for your consideration of our comments.

1 Wisconsin Department of Health Services, "2021 Medicaid Managed Care Quality Strategy," https://www.dhs.wisconsin.gov/dms/2021-managed-care-quality-strategy.pdf (Accessed May 17, 2021)
2 Severe P, Juste MA, Ambroise A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201.
3 Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med.* Apr 30 2009;360(18):1815-1826. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19339714.
4 Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 https://dx.doi.org/10.1016/S0140-6736(19)30418-0.
5 AIDS Vu Wisconsin https://aidsvu.org/local-data/united-states/midwest/wisconsin/#:~:text=In%202018%2C%20there%20were%206%2C331,were%20newly%20diagnosed%20with%20HIV.
6 Centers for Disease Control and Prevention. Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection—Medical Monitoring Project, United States, 2016 Cycle (June 2016–May 2017). HIV Surveillance Special Report 21. Revised edition. https://www.cdc.gov/hiv/ library/reports/hiv-surveillance.html. Published June 2019. Accessed February 2021. https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-21.pdf
7 Wisconsin Department of Health Services, "2021 Medicaid Managed Care Quality Strategy," https://www.dhs.wisconsin.gov/dms/2021-managed-care-quality-strategy.pdf (Accessed May 17, 2021)
8 Wisconsin Department of Health Services, "2021 Medicaid Managed Care Quality Strategy," page 44 https://www.dhs.wisconsin.gov/dms/2021-managed-care-quality-strategy.pdf (Accessed May 17, 2021)
9 Wisconsin Department of Health Services, "2021 Medicaid Managed Care Quality Strategy," page 45 https://www.dhs.wisconsin.gov/dms/2021-managed-care-quality-strategy.pdf (Accessed May 17, 2021)
10 Wisconsin Department of Health Services, "2021 Medicaid Managed Care Quality Strategy," page 73https://www.dhs.wisconsin.gov/dms/2021-managed-care-quality-strategy.pdf (Accessed May 17, 2021)
11 HIV Medicine Association. Tools for Monitoring HIV Care: HIV Clinical Quality Measures (Updated) February 2015. Available at: http://paetc.org/wp-content/uploads/2015/04/Tools_for_Monitoring_Issue_Brief_update-April-2015.pdf. Accessed April, 14, 2020.
12 National Institutes of Health (NIH) "Ten things to Know about HIV Suppression" https://www.niaid.nih.gov/news-events/10-things-know-about-hiv-suppression.
13 "Retention in Care and Adherence to ART are Critical Elements of HIV Care Interventions," Stricker, et al, AIDS and Behavior, October 2014, Volume 18, Supplement 5, pp 465–47,: https://link.springer.com/article/10.1007/s10461-013-0598-6
14 Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 http://dx.doi.org/10.1016/S0140-6736(19)30418-0 .
15 NIAID, https://www.niaid.nih.gov/news-events/undetectable-equals-untransmittable. Accessed August 1, 2018.
16 Bavinton, et al. The Opposites Attract Study of viral load, HIV treatment and HIV transmission in serodiscordant homosexual male couples: design and methods. BMC Public Health. 2014; 14: 917. doi: 10.1186/1471-2458-14-917.
17 Cohen, et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. September 1, 2016. N Engl J Med 2016; 375:830-839. DOI: 10.1056/NEJMoa1600693.

18 “HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention” National Institute of Allergy and Infectious Diseases https://www.niaid.nih.gov/diseases-conditions/treatment-prevention.
19 Centers for Disease Control and Prevention (CDC) “Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV” https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html Accessed September 20, 2019.
20 Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 http://dx.doi.org/10.1016/S0140-6736(19)30418-0.
21 Skarbinski, et al. Human immunodeficiency virus transmission at each step of the care continuum in the United States. *JAMA Intern Med*. 2015;175(4):588-596.
22 Cohen JP, et al. Estimation of the Incremental Cumulative Cost of HIV Compared with a Non-HIV Population. PharmacoEconomics - Open (2020) 4:687–696. https://doi.org/10.1007/s41669-020-00209-8..
23HIV/AIDS Bureau Performance Measures, “HIV Viral Load Suppression,” https://hab.hrsa.gov/sites/default/files/hab/About/clinical-quality-management/coremeasures.pdf Accessed May 15, 2020
24 Kaiser Family Foundation. (October 1, 2019). Medicaid and HIV. Retrieved from https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.
25 Medicaid. Adult Health Care Quality Measures. Retrieved from https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set/index.html
26 Medicaid. Medicaid & CHIP Scorecard. Retrieved from https://www.medicaid.gov/state-overviews/scorecard/index.html
27 New York State Department of Health. 2015 Blueprint. Retrieved from https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf.
28 NASHP. December 2017. Prioritizing Care: Partnering with Providers and Managed Care Organizations to Improve Health Outcomes of People Living with HIV. Retrieved from https://nashp.org/wp-content/uploads/2017/09/HIV-Affinity-Provider-MCO-Engagement-Brief.pdf.
29 New York State Department of Health. Ending the Epidemic Progress Report: March 2018. Retrieved from https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/Executive_Summary_2018_.pdf.
30 Louisiana HIV/AIDS Strategy 2017-2021, published by the Louisiana HIV Planning Group; August, 2016. Accessed at https://www.louisianahealthhub.org/wp-content/uploads/2018/10/LouisianaHIVAIDSStrategy.pdf.
31 Roscoe, C. and Hachey, D.M. (2019). Retention in HIV Care . National HIV Curriculum
32 Crawford TN (2014). Poor retention in care one-year after viral suppression: a significant predictor of viral rebound. *AIDS Care. 26*(11):1393-9. https://www.ncbi.nlm.nih.gov/pubmed/24848440.
33 Yehia BR, French B, Fleishman JA, Metlay JP, Berry SA, Korthuis PT, Agwu AL, Gebo KA (2014). Retention in care is more strongly associated with viral suppression in HIV-infected patients with lower versus higher CD4 counts. *Journal of Acquired Immune Deficiency Syndromes. 65*(3):333-9. https://www.ncbi.nlm.nih.gov/pubmed/24129370.
34 Robertson M, Laraque F, Mavronicolas H, Braunstein S, Torian L (2015). Linkage and retention in care and the time to HIV viral suppression and viral rebound – New York City. *AIDS Care. 27*(2):260-7. https://www.ncbi.nlm.nih.gov/pubmed/25244545.
35 PQA, the Pharmacy Quality Alliance, Proportion of Days Covered: Antiretroviral Medications (PDC-ARV) https://www.pqaalliance.org/measures-overview#pdc-arv. Accessed April 14, 2020.
36 Department of Health and Human Services. HIV Treatment: The Basics. March 2020. Retrieved from https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/51/hiv-treatment--the-basics. Accessed April 13, 2020
37 HIV Medicine Association. Tools for Monitoring HIV Care: HIV Clinical Quality Measures (Updated) February 2015. Available at: http://paetc.org/wp-content/uploads/2015/04/Tools_for_Monitoring_Issue_Brief_update-April-2015.pdf. Accessed April, 14, 2020.
38 Wisconsin Department of Health Services, “2021 Medicaid Managed Care Quality Strategy,” page 53 https://www.dhs.wisconsin.gov/dms/2021-managed-care-quality-strategy.pdf (Accessed May 17, 2021)
39 National Strategic Plan A Roadmap to End the Epidemic for the United States | 2021–2025 https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf
40 Id.
41 Id.
42 HIV.gov “Standing Up to Stigma” https://www.hiv.gov/hiv-basics/overview/making-a-difference/standing-up-to-stigma
43 AIDS Vu, Local Data: United States, https://aidsvu.org/local-data/united-states/ (Accessed May 11, 2021)
44 National Strategic Plan A Roadmap to End the Epidemic for the United States | 2021–2025 https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf page 21 (Accessed May 11, 2021)
45 Centers for Disease Control and Prevention. Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection—Medical Monitoring Project, United States, 2016 Cycle (June 2016–May 2017). HIV Surveillance Special Report 21. Revised edition.
https://www.cdc.gov/hiv/ library/reports/hiv-surveillance.html. Published June 2019. Accessed February 2021.
https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-21.pdf

	46 HIV.gov "Standing Up to Stigma" https://www.hiv.gov/hiv-basics/overview/making-a-difference/standing-up-to-stigma Accessed August 10, 2020 47 CDC.gov "Lesbian, Gay, Bisexual, and Transgender Health" https://www.cdc.gov/lgbthealth/index.htm 48 Mahajan, Anish P et al. "Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward." *AIDS (London, England)* vol. 22 Suppl 2,Suppl 2 (2008): S67-79. doi:10.1097/01.aids.0000327438.13291.62 49 Centers for Disease Control and Prevention, "Dealing with Stigma and Discrimination" https://www.cdc.gov/hiv/basics/livingwithhiv/stigma-discrimination.html Accessed August 10, 2020 50 HIV.gov "Standing Up to Stigma" https://www.hiv.gov/hiv-basics/overview/making-a-difference/standing-up-to-stigma Accessed August 10, 2020 51 "What is HIV stigma?" CDC.gov https://www.cdc.gov/hiv/basics/hiv-stigma/index.html 52 "What is HIV stigma?" CDC.gov https://www.cdc.gov/hiv/basics/hiv-stigma/index.html 53 HRSA's AIDS Education and Training Center (AETC) Program: https://aidsetc.org/ 54 DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH, PUBLIC NOTICE: IDENTIFYING PUBLIC HEALTH ISSUES FOR CONTINUING EDUCATION, REGISTER VOL. 66 - NO. 45 NOVEMBER 1, 2019 https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/10%25%20CE%20-%20Public%20Notice%20-%2066%20DCR%2014518-14519.pdf 55 DC.gov Board of Medicine, Continuing Education Requirements, https://dchealth.dc.gov/bomed 56 Gallant, et al. Essential Components of Effective HIV Care. *Clinical Infectious Diseases*. 2011 Dec; 53(11):1043-50 57 Wisconsin Department of Health Services, "2021 Medicaid Managed Care Quality Strategy," page 53 https://www.dhs.wisconsin.gov/dms/2021-managed-care-quality-strategy.pdf (Accessed May 17, 2021) 58 National Strategic Plan A Roadmap to End the Epidemic for the United States | 2021–2025 https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf 59 National Strategic Plan A Roadmap to End the Epidemic for the United States | 2021–2025 https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf 60 Id. 61 HIV.gov Blog, "HRSA Announces Highest HIV Viral Suppression Rate in New Ryan White HIV/AIDS Program Client-Level Data Report," Cheever, December 11, 2019 https://www.hiv.gov/blog/hrsa-announces-highest-hiv-viral-suppression-rate-new-ryan-white-hivaids-program-client-level-0 62 Wisconsin Department of Health Services, "2021 Medicaid Managed Care Quality Strategy," page 53 https://www.dhs.wisconsin.gov/dms/2021-managed-care-quality-strategy.pdf (Accessed May 17, 2021) 63 National Strategic Plan A Roadmap to End the Epidemic for the United States | 2021–2025 https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf 64 The National Center for Innovations in HIV Care, "Housing as a Determinant of HIV Health Outcomes: Results from a Systematic Review of Research 1996-2014 & Implications for Policy and Program," https://targethiv.org/sites/default/files/supporting-files/Housing%20and%20HIV%20Health%20Outcomes%20Final.pdf 65 Id. 66 The National AIDS Housing Coalition http://nationalaidshousing.org/housing-and-health/ 67 The National AIDS Housing Coalition http://nationalaidshousing.org/
20	The Wisconsin Hospital Association appreciates the opportunity to comment on the Wisconsin Department of Health Services' 2021 Medicaid Managed Care Quality Strategy. Wisconsin hospitals and health systems work with over 19 different Medicaid managed care organizations across the state, typically under contractual agreements for providing services to Medicaid recipients. While the state contracts with managed care organizations, those managed care organizations must create networks and work with providers of care. Ultimately, the providers deliver, manage and coordinate care, treatment, and services to Medicaid patients. We believe that a Medicaid managed care quality strategy must take into account how well managed care entities are working with and coordinating with their provider partners. To that end, we offer recommendations for: including providers more directly

	as key stakeholders; simplifying administrative processes for providers; and increasing transparency in the program. Including Providers More Directly as Key Stakeholders WHA members have a strong interest in partnering with managed care organizations and the Department to identify opportunities for improvement in Medicaid managed care. We believe the Department's overall Medicaid managed care strategy must include providers as a key stakeholder. We recommend strengthening the Department's strategy by more actively including a process for engaging hospitals and health systems directly in discussions for achieving positive outcomes for Medicaid patients through Medicaid managed care. Specifically, the Department should create a forum that would include both hospitals and managed care organizations to discuss barriers, opportunities and ideas related to achieving the Department's goals for Medicaid managed care. For example, quality incentives or penalties imposed upon managed care organizations often result in greater monitoring and reporting by providers. As part of an ongoing forum, new quality incentives or penalties should be discussed and vetted in order to ensure positive patient outcomes without significant added administrative burden and cost on providers. WHA has long supported hospital quality improvement programs. We believe the Medicaid program would benefit from greater dialogue with hospitals and health systems about quality improvement programs in Medicaid managed care before they are implemented. The Department indicates on page 41 of the proposal that, "DMS has identified opportunities to improve the quality and standardization of BadgerCare Plus and Medicaid SSI HMOs and is in the exploratory phases of several initiatives to create policy during this quality strategy period. These efforts will improve oversight of the HMO program and allow for annual review and updates of our payment reform strategies to improve the quality and standardization and they are evaluating options." We understand that one option under consideration by DMS includes changing the requirements for Medicaid managed care participation in a region, potentially limiting the number of participating managed care organizations. Because changes to the Medicaid managed care entities impact the providers with which they contract, and ultimately the patients seeking care from those providers, we recommend that the Department allow for public review of all such policy options intended to improve the quality and standardization of HMOs. Simplifying Administrative Processes Wisconsin is fortunate to have a competitive and pluralistic insurance market, and many insurers that participate in Medicaid managed care also participate in Wisconsin's insurance exchange. This offers choice and continuity for those seeking coverage after leaving the Medicaid program. While this benefits Wisconsin, the number of plans in the Medicaid program also offers administrative challenges for hospitals and health systems when managed care organizations have differing administrative processes and requirements.

	Providers understand the managed care organizations' interest, on behalf of the Department, in ensuring appropriate care and utilization. However, differences in prior authorization practices, claims denial policies and even appeal timelines can result in care delays, process disruptions and added costs for providers. In Southeast Wisconsin, for example, there are eight larger BadgerCarePlus HMO organizations meaning that providers may need to accommodate up to eight different processes for obtaining prior authorizations for particular services for that population. Standardizing processes would reduce the administrative burden for patients, providers and payers. We recommend that the Department's Medicaid Managed Care Quality Strategy include steps to standardize processes leading to more efficient care in the Medicaid program. Greater Transparency The Wisconsin Medicaid program can be a dizzyingly complex program but one with a laudable goal of ensuring access to health care services for some of our most vulnerable patients. Finding information about the program can be difficult. For example, the Medicaid Managed Care Quality Strategy proposal indicates that data is collected about grievances and denials. However, such data does not appear to be readily available. We recommend that the Wisconsin Medicaid program would benefit greatly from more accessible and transparent information related to Medicaid managed care. For example, data about timely claims processing, number of denials, and prior authorization requests, could be beneficial in highlighting areas of burden and identifying finding ways to streamline these processes for all parties. As another example, hospitals have experienced difficulties finding information on the Medicaid managed care potentially preventable readmission program. We encourage the Department to identify ways to improve transparency in managed care requirements, particularly those that impact hospitals like the recently implemented potentially preventable readmission program. We recommend that the Department's Medicaid Managed Care Quality Strategy include steps toward more data transparency. Summary We appreciate the opportunity to provide comments on the Department's Medicaid Managed Care Quality Strategy proposal. As indicated, we believe any Medicaid HMO Quality Strategy should recognize and include hospitals and health systems as key partners in delivering care. How well managed care organizations work with their provider partners is critical to ultimately meeting the Department's programmatic goals and ensuring the best care possible for Medicaid patients.
21	Please find attached the comments submitted on behalf of the Wisconsin Assisted Living Association (WALA) as it pertains to the 2021 Medicaid Managed Care Quality Strategy. Thank you for the opportunity to provide comments and please let me know if you have any questions. Thank you for the opportunity to submit comments regarding the 2021 Medicaid Managed Care Quality Strategy.

The Wisconsin Assisted Living Association (WALA) represents the majority of Wisconsin's assisted living providers, with over 1,500 facility members. This includes community-based residential facilities (CBRF), residential care apartment complexes (RCAC), and adult family homes (AFH).

Care Management/Duplication of Services

The Family Care program was created with the intention of providing the best quality of care to all individuals participating in the program. We believe the Family Care program should continue upon this tract and distinguish between licensed assisted living settings and individuals that are receiving services in their own personal home. Namely, there are certain oversight activities within the Family Care program that are appropriate for individuals receiving services in their own personal home versus a licensed assisted living facility that is already governed by Wisconsin state regulations. Having any duplication of services that are mandated by state regulations and the Family Care program detracts from the ability of a licensed assisted living facility to provide quality care.

Therefore, Pre-Paid Inpatient Health Plans (PIHPs) should not provide care management services to their members that reside in a licensed assisted living facility.

According to the current Wisconsin Family Care and Family Care Partnership Long-Term Care Waiver Programs (Waiver), PIHPs are required to provide care management services which include:

- A comprehensive assessment of the member's strength, abilities, functional limitations, lifestyle, personal circumstances, values, preferences, and choices.
- Development of an individualized plan of care.
- Authorization for the purchase of paid services identified in the plan of care.
- Monitoring of the delivery and quality of the paid services identified in the plan of care.
- Monitoring of the member's circumstances and ongoing health and well-being.
- Maintenance of a member record and all documentation associated with the delivery of services and any required waiver procedures.

As a means to enhance the quality of services of both PIHPs and licensed assisted living settings, PIHPs should not be required to provide the same care management services that a licensed assisted living provider is already providing under Wisconsin state law – DHS 83.35 (CBRF), DHS 88.06 (AFH), and DHS 89.26 (RCAC). While we understand it may be necessary for a PIHP to provide care management services to individuals that are residing in their own personal home, this is unnecessary in licensed assisted living settings as it creates a duplication of services and increases the cost for services. Further, as both assisted living facilities and PIHPs are enduring a workforce crisis, it is not a good use of time, resources, or money to have two nurses provide two assessments on the same resident. This duplication not only intensifies the workforce crisis as it creates additional time constraints and lessens the efficiency needed to provide care and services.

	Pay for Performance We agree and appreciate the Division of Medicaid's position of continuing to pursue Pay for Performance (P4P) initiatives within the Family Care program. In particular, the Assisted Living Quality Improvement program that is tied with the Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL) is a great example. Unfortunately, while the intent of this program is good, all of the incentives are provided directly to the PIHP. Yet, it is the assisted living facility that is conducting and performing all of the quality initiatives tied within this P4P but they are not receiving the benefits. To further enhance and promote quality within assisted living facilities, all funding and incentives as part of the Assisted Living Quality Improvement program and any other P4P initiatives should be provided directly to the assisted living facility. **Transitions of Care** We fully support the need to enhance the transition of care for individuals between a hospital, nursing home, and assisted living facility. Having strong processes and funding programs in place ensures health information flows between applicable health care and long-term care providers. Namely, funding should be provided to assisted living facilities that would afford them the opportunity to create and maintain an electronic health record system that is necessary to the health care continuum. Further, PIHPs should be required to provide the necessary health information about their member(s) to hospitals, nursing homes, and assisted living facilities. **Integrated Care** The care and services that an individual requires can be complex. Unfortunately, this can be exacerbated when an individual requires acute care and long-term care services. Given the different payor sources for each, that can cause competing and differing approaches to the care an individual receives. Integrating acute care and long-term care is vital to not only enhancing the quality of care/services provided to an individual, but also lowers costs on an already taxed system.
22	Below, please find comments related to the quality of the Family Care program as DHS considers its 3-year Medicaid Managed Care Quality Strategy: MCO rate adequacy: rates are wholly insufficient to provide the expected quality of care for members, with the costs of care exceeding the daily reimbursement by $50-$10 PER DAY. We therefore have to limit the number of Family Care enrollees in our facilities so that our private pay residents offset the Family Care losses, a hidden tax on those Wisconsinites. MCO rate negotiation process: there is zero ability to negotiate contracted rates with MCOs based on our needs and/or our assessment of member needs. We are told "this is the best we can offer, take it or leave it." This requires us to be very cautious about taking placements of Family Care enrollees, especially those who are projected to have long lengths of stay. Rate cuts or freezes are the norm, and increases have been non-existent. The rate cuts we are being forced to take after Covid are unconscionable. There MUST be a standard

	medical loss ratio implemented to ensure capitated rate increases from DHS to the MCOs are passed along to providers. Redundancies in the care management process are also the norm. Our facility staff are the experts on the needs of our residents and manage the resident care needs, so care management from MCO staff is not essential. CASE management should stay with the MCOs, but care management is the part that we do and that we should be paid for, not the MCOs. The functional screen is a fatally flawed tool that is shrouded in secrecy, not completed by the staff who know the resident best, and provided no added value to anyone. It should be entirely eliminated as the source of rate setting in favor of a cross-organizational and interdisciplinary assessment. Family Care has been a largely failed experiment due to the power that MCOs have amassed and the subservient position that providers have been put in, as there is little incentive for providers to admit Family Care members when we receive such poor reimbursement and when we have such little input into the assessed care needs of the member. Ultimately, it has created a "haves" and "have-nots" environment in assisted living, where those who qualify for Family Care have to settle for facilities that are willing to take substandard rates because their care and/or environment doesn't attract private pay admissions.
23	This letter is intended to serve as a formal response to your request for public comment on the 2021 Medicaid Managed Care Quality Strategy. Federal regulations ensure each State contracting with a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Public Health Associate Program (PAHP) drafts and implements a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP, or PCCM entity, including self-directed services. At GT Independence, we believe people should live their lives, according to their own vision. Self-Determination is one of our core values; we believe that everyone should have the freedom to choose how they live their lives and who provides their needed supports. The Quality Strategy describes the specific strategies Wisconsin will implement to best meet the health care, service, and support needs of Wisconsin Medicaid members. One of the State's goals is community inclusion and a person's sense of choice and control over their services. GT Independence has the mission of serving individuals by allowing them the choice to manage their own program through self-direction and support of fiscal intermediary services. Individuals with intellectual disabilities, developmental disabilities, autism spectrum disabilities and others with long-term care needs face many challenges every day including how they will obtain and keep the assistance they need allowing them to live a full and rich life in the community. There are many different long-term care options available to most individuals however only a limited few which truly provide the freedom and ability for individuals to oversee how they live their life.

	Self-direction offers individuals the ability to have quality caregivers, of their choosing, and decision authority over their care delivery. GT Independence recognizes that Wisconsin's Quality Strategy includes meeting the needs of everyone with quality care, ensuring person-centered planning, access to care and choice, to provide detailed description of options available, access to technology, access to quality caregivers and to increase caregiver pay rates. GT Independence believes strongly that each participant is provided the opportunity to live a life of their choosing. GT offers the following comments for the Department's consideration: As a result of the reduction in rates for Fiscal Intermediary (FI) services, some providers are opting out of providing these services or offering a reduced cost service that may impact overall quality. The state should consider creating a minimum quality standard for FI providers and ensure that current and future providers meet that standard. This will likely result in a need for increased rates related to the FI service. In any approach, pricing should reflect and support the scope of work and established quality standards should be expected. Prices vary around the country, but the national average is between $100-110 PMPM, excluding EVV requirements. Prior to procurement in 2018, the State of Washington dug into FMS pricing research and found a mid-point of $101.33 PMPM. The Aging and Disability Resource Center (ADRC) plays a significant role in handling FI program selection. GT Independence believes training regarding the role of a FI provider would be impactful and beneficial within the program selection process led by the ADRC teams. Understanding the roles and responsibilities of the FI provider is vital in ensuring that the appropriate providers are selected to meet the needs of the participants Currently, there is a workforce shortage for caregivers throughout the State. GT believes that providing competitive pay rates will increase the number of quality caregivers available. Increasing pay rates will meet the State's goal of providing access to quality caregivers, which will successively improve the workforce shortage. In closing, GT is grateful for the opportunity to provide public comment regarding 2021 Medicaid Managed Care Quality Strategy. GT Independence is one of the nation's leaders in supporting participants with the ability to self-direct their services. GT looks forward to collaborating and working together to empower participants in Wisconsin, to truly live a self-directed life of their choosing.

f. Accreditation Deeming Plan

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

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

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

UNITEDHEALTHCARE COMMUNITY PLAN	Accredited by NCQA	Commercial, Medicare, Exchange

1. The current accreditation deeming plan can be found on the ForwardHealth website as a PDF here: https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/pdf/2019_2021_HMO_Accreditation_Deeming_Plan.pdf.spage.

g. Supporting Documents for CMS Compliance Matrix Detail

BadgerCare Plus and SSI HMO Contract:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Contracts/Home.htm.spage

Family Care and Family Care Partnership Contract:

https://www.dhs.wisconsin.gov/familycare/mcos/contract.htm

BadgerCare Plus and SSI HMO Quality Guide:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/Home.htm.spage

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

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

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

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

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