# 2021 Medicaid Managed Care Quality Strategy Overview

This is a summary of the extensive Wisconsin Department of Health Services 2021 Medicaid Managed Care Quality Strategy (Quality Strategy). The information in the Quality Strategy is structured according to federal requirements. Significant improvements were made to this year's Quality Strategy compared to the last quality strategy published in 2018.

The five major areas of improvement to note in the 2021 Quality Strategy are:

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

See the Effectiveness Evaluation for in-depth detail of each key improvement area. Below is a synopsis of the content outlined in the 2021 Managed Care Quality Strategy:

1. Introduction
    a. **Purpose**: To outline managed care quality goals, objectives, strategies, and programs intended to achieve the overarching vision of DMS, as well as to establish a process for monitoring progress toward these goals. Submitted to CMS every three years, meets the federal requirements of 42 C.F.R. §438.340
    b. **Scope**: Family Care and Partnership MCOs (also known as PIHPs), BadgerCare Plus and SSI HMOs, Care4Kids PIHP, Children Come First & Wraparound Milwaukee PIHPs
    c. **History of Medicaid in Wisconsin**: See timeline of program development and key milestones
2. Methods and Process for Development
    a. **Public Comment Process**: Open April 26 to May 21, 2021.
    b. **Process for Review and Update:** DMS reviews at a minimum of every three years. Annual effectiveness evaluation determines when changes should be made.
3. Organizational Goals, Objectives, and Foundational Principles
    a. **DHS' Mission, Vision, Values**: Mission "To protect and promote the health and safety of the people of Wisconsin."
    b. **Division of Medicaid Services' (DMS) Mission, Vision, Values:** Mission of "Improving lives through high-value services that promote health, well-being and independence."
    c. **Foundational Principles:** Values that guided the development of the DMS quality goals, strategies, and programs, and are reinforced through activities, interventions, measures, and performance monitoring

d. **DMS Quality Goals and Objectives**: 12 Objectives for Acute and Primary Care, 17 Objectives for Long-Term Care, and all currently captured Care4Kids performance measures. Each objective supports its connected goal and is tied to a performance indicator for which historical data is provided and targets can be developed.

4. DMS Quality Strategies
    a. **Payment Strategies:** Allow DMS to uphold the foundational principle of cost-effectiveness and are utilized to direct focus on key objectives
        i. **Enhanced Value-Based Purchasing:** Financial incentives, withholds, and payments based on reported outcomes. HMOs participate in P4P for HEDIS measure reporting and a 2021 Performance Improvement Project. MCOs participate in P4P for member satisfaction, competitive integrated employment, and quality of assisted living communities.
        ii. **Reduce avoidable, non-value added care:** The acute care program areas 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 to promote appropriate access to care (i.e., primary care or urgent care rather than emergency room, when appropriate).
    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
        i. **Enhance care coordination and person-centered care:** DMS has requirements for effective care coordination and management that will help improve care, health outcomes, and experience of care for the members, and will ensure appropriate utilization of services.
        ii. **Improve 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. BadgerCare Plus and SSI HMOs coordinate care for specific populations using the OB Medical Home and HIV/AIDS health home. DMS is also developing a pilot hub and spoke model of health home care for those with severe substance use disorder.
        iii. **Ensure health and safety:** DMS requires 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. PIHPs engage in discovery, investigation, remediation, and prevention of incidents that may compromise the health and safety of members.

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.
    i. **Promote member engagement:** DMS develops an HMO Report Card to help members select their health plan based on quality ratings and is planning to launch an HMO Selection Tool through the online member portal. DMS is also requiring HMOs to conduct an organizational self-assessment on cultural competence, and requiring HMOs to incorporate the national Culturally and Linguistically Appropriate Services (CLAS) standards to address the needs of culturally diverse Medicaid members.
    ii. **Long-term care choice strategy:** DMS develops an MCO Scorecard to help members select their MCO (PIHP) based on quality ratings. Member participation in the NCI-AD and NCI-IPS surveys provide DMS with data on member experience of engagement and choice. DMS prioritization of competitive integrated employment is a specific initiative to enable members to achieve the level of choice and engagement in their community activities.

5. Enabling Infrastructure: Data and Technology
    a. **Accelerate quality monitoring:** DMS is developing an updated State Medicaid Health Information Technology plan and data management strategy to support the quality monitoring plan and assess progress towards goals and objectives.
    b. **Use technology to engage members:** DMS explores greater use of telehealth, remote patient monitoring, member education, and other tools to engage members in their care. 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 Overview: This section provides an overview of the managed care programs serving Wisconsin Medicaid members. The overviews describe the activities and interventions of each program that are designed to achieve managed care quality goals and objectives.
7. Quality Assurance: This section describes how DMS complies with federal Medicaid managed care rule requirements in §438.340.
    a. **Access Standards:** The standards for access to care for which all WI managed care plans must meet. The standards include network adequacy, availability, and timeliness of services in acute care, long-term care, and children's services.
    b. **Service Standards:** Outlines the governing evidence-based clinical practice compliance guidelines that DMS mandates of HMOs and PIHPs in meeting the needs of members with special health care needs, identifying and addressing health disparities, and meeting the transitions of care requirements in acute care, long-term care and children's services.

c. **Quality Assessment and Performance Improvement:** Addresses the scope of quality assessment and performance improvement within the managed care programs. All programs require annual performance improvement projects to continuously advance quality of member care.
d. **EQRO:** Addresses the federally-required and DMS-contracted independent quality review and monitoring role of the EQRO; coordinated processes to advance quality assessment, monitoring, and improvement in the acute and long term care programs
e. **Remediation:** Remediation plans are the formal methods for addressing underlying issues in programs, or noncompliance with contracted services. Provides an overview of each program's sanctions processes and authority for remediation, as appropriate.

8. Appendices
    a. **Quality Framework:** The structural tool used by DMS to identify and align the elements of the Quality Strategy, and evaluate its programs, activities, and interventions. The framework consists of 13 domains that are used to inform decisions, provide a roadmap, and assist in planning efforts surrounding the Quality Strategy.
    b. **Glossary:** Comprises a list of key terms used throughout the Quality Strategy or that are important for the readers to know in order to fully orient themselves to the strategy document.
    c. **Quality Measure Matrix:** Connects specific quality indicators referenced in materials linked in Appendix 8g to the specific programs and initiatives for which the quality measures are tied, and that DMS monitors for improvement.
    d. **Summary of Current Enabling Data and Technology Assets:** Provides an overview of the current data and technology resources that enables the acute care and long-term care program areas.
    e. **Strategy Summary Public Comments:** This section will include the public and stakeholder feedback on the Quality Strategy provided during the 30-day public comment period following the release of the Quality Strategy to the public.
    f. **Accreditation Deeming Plan:** A crosswalk between federal requirements, standards used by NCQA for accredited health plans, and DMS's HMO contract and certification application materials. Provides 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 for HMOs.
    g. **Supporting Documents for CMS Compliance Matrix Detail:** Additional documents that help the reader understand why a measure is collected and provide detail on the utilization of those quality indicators outlined in the Quality Strategy. The supporting documents consist of the contracts, EQRO reports, quality guides, and other references.