WISCONSIN DEPARTMENT of HEALTH SERVICES

Medicaid Managed Care Quality Strategy 2025-2027

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Introduction

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

The Wisconsin Department of Health Services (DHS), Division of Medicaid Services (DMS), has broad quality priorities that include:

- Improving access, member choice, and health equity
- Promoting appropriate, efficient, and effective care
- Focusing on patient or person-centered care and superior clinical and personal outcomes
- Employing principles of evidence-based continuous quality improvement.

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

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

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

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

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

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

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

Program Name	Managed Care Entity Type	Managed Care Authority	Managed Care Program Type
BadgerCare Plus (BC+) SSI	Health Maintenance Organizations (HMOs)	Section 1932(a) of the Social Security Act	Combined Medicaid and CHIP

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

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

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

Program Name	Managed Care Entity Type	Managed Care Authority	Managed Care Program Type
Family Care Partnership	Managed Care Organizations, (MCO) Prepaid Inpatient Health Plans (PIHP)	1915(b) of the Social Security Act	Medicaid
Contracted Managed Care Organizations		**Populations Covered by Family Care and Partnership MCOs**	
Family Care • Community Care, Inc. • Lakeland Care, Inc. • Inclusa • My Choice Wisconsin Partnership • Community Care Health Plan • Independent Care (iCare) Health Plan • My Choice Wisconsin Health Plan		Family Care • Individual 18 years old or older • Frail elder or an adult with a disability • Financially eligible for full-benefit Medicaid • Functionally eligible for Family Care as assessed through the Long-Term Care Functional Screen • Have a long-term care condition that will last more than 90 days Partnership • Individual 18 years old or older • Frail elder or an adult with a disability • Financially eligible for Medicaid • Functionally eligible for Partnership as assessed through the Long-Term Care Functional Screen • Have a long-term care condition that will last more than 90 days • Live in a county that offers Partnership	
Program Information		**Covered Services**	

• Family Care program information • Partnership program information • Family Care, Family Care Partnership and PACE: MCO contracts	Benefit information: Family Care offers long-term care services to its members. Services can range from help with daily tasks at home to mental health. Learn more about Family Care benefits. Partnership offers both services covered by Family Care and Medicaid card services for long-term care. Learn more about services included in Partnership MCOs.

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

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

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

Program Information		**Covered Services**	
Care4Kids program information		• Care4Kids PIHP contract • ForwardHealth website Care4Kids has many benefits. These include: • Health care coordination • All Medicaid-covered benefits • Dental and vision care There are some services that the PIHP does not provide. These services	

	are instead provided through fee-for-service coverage. This means PIHP members can get these services from any doctor or provider that is a registered Medicaid provider. These services include: • Behavioral treatment services, including treatment for autism spectrum disorder • Certain tuberculosis related services • Chiropractic services • Community recovery services (CRS), community support program, (CSP), comprehensive community services (CCS) and crisis intervention services • Hub and Spoke Integrated Recovery Support Services Health Home for Substance Use Disorder (SUD) Treatment pilot program. • Non-emergency medical transportation (NEMT) • Pharmacy services, such as prescription and over the counter drugs and diabetic supplies • Prenatal care coordination (PNCC) • School-based services, such as audiology, physical therapy, and speech therapy, identified in a student's individualized education plan (IEP) and provided by a school district or cooperative education service agency (CESA). • Targeted Case Management (TCM)

Effectiveness of the Previous Quality Strategy

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

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

Goals and Objectives

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

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

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

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

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

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

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

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

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

a) Improve BC+ HMO members' utilization of primary care and preventive services, including periodic well-check visits

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

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

(HealthCheck), immunizations, colon and breast cancer screenings, enhanced schedule of lead screenings, and dental care.

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

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

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

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

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

c) Each Family Care and Partnership MCO will increase the percentage of members aged 18-64 who are working in Competitive Integrated Employment settings by 3% annually over their previous year baselines.

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

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

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

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

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

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

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

DMS continues to increase understanding of the member experience related to accessing behavioral health and substance use disorder services. Over the next few years, systems will be in place that will allow DMS to develop new outcome measures in this area through improved access to data. DMS will further explore measures for behavioral health provider appeals, length of time members wait to receive treatment, and required prior authorizations and related denials associated with these services in each managed care program. Another area of interest includes the impact of increased telehealth availability on access to psychiatric prescribers and non-prescribers in rural areas. In 2025, program members will have access to a peer recovery coach following a substance use overdose to coordinate care and help program members access behavioral health care. DMS will track access to this new benefit to determine positive impact to membership.

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

DMS recognizes that improving health equity is a foundational strategy for improving the health of Wisconsin's residents and improving the experience of care for Wisconsinites. Persistent and systematic differences in health outcomes for different Wisconsin populations are well documented, and a key component of Healthiest Wisconsin 2026. Health disparities are often related to the conditions in which people are born, live, grow, work, and age – also called the social determinants of health (SDOH). Economic resources and geographical location have a proven sizable impact on health outcomes. Partnerships between communities and the health care system are critical for improving health across the lifespan and reducing disparities in health outcomes.

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

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

b) Family Care and Partnership MCOs will increase the percentage of member-centered service plans that are comprehensive by properly addressing members' assessed needs and personal goals by 14.5% over 2023 MY 2027.

c) Care4Kids PIHP will increase the percentage of unique member needs and services addressed through timely follow, as measured through the annual Care Management Review conducted by the EQRO, from a baseline of 84% (MY23) to 90% by MY2027.

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

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

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

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

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

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

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

Outcome measures:

c) DMS will reduce the rate of Live Births Weighing Less Than 2,500 Grams (LBW-CH) from 10.6% (CY 2022) for Wisconsin Medicaid birthing members to be at or below the overall statewide baseline rate of 7.8% for all birthing parents (CY 2022) by 2027. DMS will reduce this rate for the African American or Black, Not Hispanic or Latino population (18.4% baseline) by 1% each measurement year.

d) DMS will reduce the rate of low-risk C-Sections among targeted race/ethnicity groups by 1% each year.

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

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

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

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

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

b) Increasing timely comprehensive initial assessment, completed within thirty days of enrollment, of a child's health to identify acute

or chronic physical health conditions; oral health concerns; and developmental or behavioral health-related needs.

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

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

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

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

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

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

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

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

b) In Care4Kids, children will have a timely (completed within two days of enrollment) out-of-home health screen to identify any immediate medical, urgent mental health, or dental needs 56% of the time by MY 2027.

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

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

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

The CMR is completed by the external quality review organization (EQRO). A CMR is an optional activity identified in CMS External

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

Objective 5: By MY 2026, Family Care and Partnership MCOs will have an overall quality compliance review (QCR) score of 97% or higher.

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

Standards are reviewed in a two-year cycle for each MCO. The first year of the cycle includes the MCO Standards, followed by Quality Assessment and Performance Improvement (QAPI) and Grievance Standards in the second year. The baseline overall compliance score of 95.6% is based on the fiscal year 2023-2024 report completed in 2024. Family Care and Partnership MCOs will be required to obtain an overall QCR of 97% or higher by the fiscal year 2025-2026 report (MY 2026).

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

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

Quality Metrics and Performance Targets

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

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

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

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

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

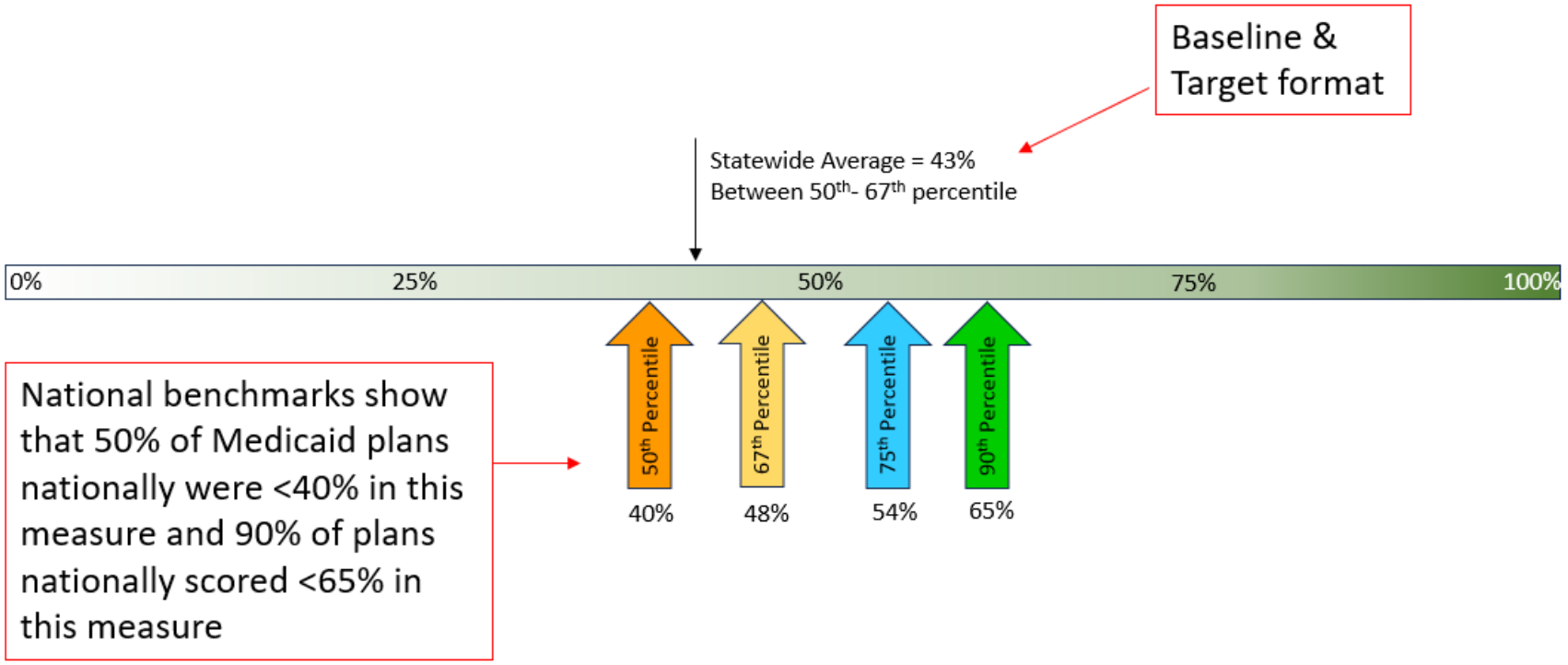

Figure 1: Example of HEDIS measure results compared to national benchmarks

Table 4: Goals, Objectives, and Performance Measures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	which there was follow-up.	Above 75th Percentile	(2026) – 75th Percentile (2027) – 75th Percentile	
5b.	Reduce the number of restrictive measures applications for individuals with behavioral health needs in Family Care and Partnership by 3% over the next 3 years (or 1% per year over the next 3 years). *(State-Developed Measure, LTSS Measure)*	(2023) 162 restrictive measure applications	(2025) – 160 (2026) – 158 (2027) – 156 (Reduce by 3% by 2027 or 1% per year over the next 3 years.)	FC and FCP
5c.	Reduce the number of Family Care members who are admitted to IMDs multiple times in a calendar year by 7% over the next 3 years. *(State-Developed Measure, LTSS Measure)*	(2023) 25.5% of FC members admitted to an IMD were readmitted at least once in the same year.	(2025) – 23.5% (2026) – 21% (2027) – 18.5%	FC
Goal 2: Reduce health disparities and support underserved populations providing person-centered services and supports.				
Objective 1: By MY 2027, address members' Health-Related Social Needs (HRSNs) identified through screening by ensuring they receive a corresponding intervention. Every managed care member is screened at least once annually for HRSNs, and each managed care program has established policies and procedures for addressing identified HRSN needs.				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
1a.	**Social Need Screening and Intervention (SNS)** *(HEDIS Measure)* The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive. Six rates are reported: 1) Food screening; 2) Food intervention; 3) Housing screening; 4) Housing intervention;	Baseline data available MY 2025	**BC+** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **SSI** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile (targets apply to each of the	BC+ and SSI

	5) Transportation screening; 6) Transportation intervention		six screenings)	
1a.	Increase the percentage of Family Care and Family Care Partnership members who respond positively to the question of how well their supports and services meet their needs. *(State-Developed Measure, LTSS)*	(2022) FC= 82% FCP = 78%	Increase of 1% each year	FC and FCP
1b.	Increase the percentage of member-centered service plans that are comprehensive by properly addressing members' assessed needs and personal goals. *(State-Developed Measure, LTSS Measure)*	(2023) Combined FC and FCP = 75.5% based on CMS 372 Report.	(2025) – 80% (2026) – 85% (2027) – 90% (Target measures are combined FC and FCP)	FC and FCP
1c.	Increase the percentage of unique member needs and services addressed through timely follow-up by 6% over the 2023 baseline of 84% as measured through the annual Care Management Review conducted by the EQRO. *(State-Developed Measure)*	(2023) 84%	(2025) – 86% (2026) – 88% (2027) – 90%	C4K
Objective 2: Improve healthy birth outcomes by increasing utilization of certain maternity services, by reducing rates of babies with low birth weights, and by reducing rates of C-section utilization, while also reducing racial and ethnic disparities in these measures, by MY 2027.				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
2a.	**Prenatal and Postpartum Care (PPC)** *(HEDIS Measure)* The percentage of deliveries in which women had a prenatal care visit in the first trimester or had a postpartum visit on or between 7 and 84 days after delivery.	**BC+ and SSI** Baseline data available MY 2024	**BC+** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **SSI** (2025) – 50th Percentile	BC+ and SSI

			(2026) – 67th Percentile (2027) – 75th Percentile	
2b.	**Postpartum Depression Screening and Follow-up (PDS-E)** *(HEDIS Measure)* The percentage of deliveries in which members were screened for clinical depression during the postpartum period and received follow-up care within 30 days if screening was positive.	Baseline available in MY 2025.	**BC+** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **SSI** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI
2b.	**Prenatal Depression Screening and Follow-Up (PND-E)** *(HEDIS Measure)* The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care.	Baseline available in MY 2025.	**BC+** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile **SSI** (2025) – 50th Percentile (2026) – 67th Percentile (2027) – 75th Percentile	BC+ and SSI
2c.	**Live Births Weighing Less than 2,500 Grams (LBW-CH)** *(Centers for Disease Control and Prevention//National Center for Health Statistics Measure)* Percentage of live births weighing less than 2,500 grams. (A lower rate indicates better performance)	(2022) Medicaid rate = 10.6% White, Not Hispanic/Latino = 8.5% African American/Black, Not Hispanic/Latino = 18.4%	Reduce Medicaid rate to equal Statewide rate of 7.8% by 2027. Reduce the percentage by 1% from baseline for the African American/Black group for each measurement year.	BC+ and SSI
2d.	**Low-Risk Cesarean Delivery (LRCD-CH)** Percentage of nulliparous (first birth), term (37 or more completed weeks based on the obstetric estimate), singleton (one fetus), in a cephalic presentation (head-first) births delivered by	(2022) White, Not Hispanic/Latino = 21.8% Asian, Not Hispanic/Latino =	Reduce the percentage by 1% from baseline for each measurement year for the groups listed below: • Asian, Not	BC+ and SSI

	cesarean during the measurement year. (A lower rate indicates better performance.) *(Centers for Disease Control and Prevention//National Center for Health Statistics Measure)*	28.3% African American/Black, Not Hispanic/Latino = 24% Hispanic or Latino = 23%	Hispanic/Latino • African American/Black, Not Hispanic/Latino • Hispanic or Latino	
Objective 3: Increase stratification of performance measures by member demographics with a goal to identify and address health disparities by MY 2027.				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
3a.	Increase number of federally reported Child and Adult Core Set measures for Wisconsin's Medicaid and CHIP populations that are stratified by member demographics (race, ethnicity, sex, and geography), beginning in 2025 through 2028, per CMS' implementation timeline. *(State-Developed Measure)*	(2024) 0% of mandatory measures	(2025) – 25% of mandatory measures (as defined by CMS) (2026/2027) – 50% of mandatory measures (as defined by CMS) (2028) – 100% of mandatory measures (as defined by CMS)	BC+, SSI, C4K, FC, and FCP
3b.	Percentage of Managed Care Plans that stratify required HEDIS measures in accordance with HEDIS specifications for race and ethnicity. *(State-Developed Measure)*	MY 2024 Baseline of 22 HEDIS Measures	(2027) – 100% of Managed Care Plans	BC+, SSI, and C4K
Objective 4: Care4Kids will prioritize identification, assessment, and coordination of care for their members' health concerns when entering out-of-home care by MY 2027.				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
4a., 4b.	**Timely Comprehensive Initial Health Assessment** *(State-Developed Measure)*	(2022) 69.9%	(2025) – 74% (2026) – 79% (2027) – 85%	C4K

	The percent of children newly enrolled in Care4Kids during the reporting period who have a Comprehensive Initial Health Assessment completed within 30 days of their enrollment date.			
4c.	**Care Plan Input** *(State-Developed Measure)* The number of member records reviewed with a care plan developed with input from all required persons including the child's parent and/ or legal guardian.	(2023) 24%	(2025) – 29% (2026) – 34% (2027) – 39%	C4K
Goal 3: Support overall quality improvement through compliance with federal requirements, contracts, and Wisconsin benchmarks.				
Objective 1: Managed care plans in all programs will have at least 90% compliance in network adequacy standards beginning in MY 2025.				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
1a.	Percentage of managed care plans that are at or above 90% compliance with provider network drive time and distance standards and provider to member ratio requirements for each county in their service area. *(State-Developed Measure)*	(2023) BC+ = 84.6% SSI =88.9% C4K = 100% FC = 100% FCP = 100% *Represents percentage of managed care plans that meet or exceed the 90% compliance standard	(2025) – 90% (2026) – 95% (2027) – 100% (targets apply to all program areas and managed care entities)	BC+, SSI, C4K, FC, and FCP
Objective 2: Managed care plans will continue to screen each new members to identify specific health and health related social needs (i.e., member needs screening).				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
2a.	Increase percentage of HMOs achieving minimum standards of 35% for BC+ and 50% for SSI for screening new members within contracted timelines	(2023) BC+ = 8% SSI = 60% *Represents percentage of HMOs	(2025) – 33% of HMOs (2026) – 67% of HMOs (2027) – 100% of HMOs	BC+ and SSI

	and expectations. *(State-Developed Measure)*	that meet or exceed the minimum screening standards.		
2b.	**Timely Out-of-Home Care Health Screen** *(State-Developed Measure)* The percent of children who had a timely out-of-home health screen to identify any immediate medical, urgent mental health, or dental needs.	(2023) 48%	(2025) - 50% (2026) - 53% (2027) - 56%	C4K
Objective 3: By MY 2027, BadgerCare Plus and Medicaid SSI HMOs and Care4Kids will have a completion score of 80% or higher for the Annual Compliance Tool (ACT).				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
3a.	Increase percentage of HMOs achieving a completion score of at least 80% for the ACT. *(State-Developed Measure)*	BC+, SSI, and C4K Baseline will be established following the 2024 review cycle.	(2025) – 33% of plans (2026) – 67% of plans (2027) – 100% of plans	BC+, SSI, and C4K
Objective 4: The Family Care and Partnership MCOs will have an overall care management review (CMR) score of 90% or higher for both Family Care and Partnership programs by MY 2027**.**				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
4a.	Percent of care management review (CMR) standards met for all indicators in Protocol 9: Conducting Focus Studies of Health Care Quality *(State-Developed Measure)*	**FY2023-2024** Family Care (FC) =84.8% Family Care Partnership (FCP) = 80.2%	(2025) – 86% (2026) – 88% (2027) – 90%	FC and FCP
Objective 5: By MY 2026, Family Care and Partnership MCOs will have an overall quality compliance review (QCR) score of 97% or higher.				
Quality measure		**Statewide performance baseline (year)**	**Statewide performance target (year)**	**Program(s)**
5a., 5b.	**QCR compliance review score** *(State-Developed Measure)* QCR assesses the strengths and weaknesses of the	Baseline established using the FY2023-2024 report. 95.6%	FY2025-2026 report. (2026) – 97%	FC and FCP

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

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

Measure Name and Stratification	Applies to BadgerCare Plus HMOs	Applies to SSI HMOs
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB); Total	X	X
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E); Continuation and Maintenance Phase	X	
Asthma Medication Ratio (AMR); Total	X	X
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) - Blood Glucose and Cholesterol Testing - Total - Blood Glucose Testing - Total - Cholesterol Testing - Total	X	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP); Total	X	

Measure Name and Stratification	Applies to BadgerCare Plus HMOs	Applies to SSI HMOs
Breast Cancer Screening (BCS-E)	X	X
Controlling High Blood Pressure (CBP)	X	X
Cervical Cancer Screening (CCS)	X	X
Chlamydia Screening (CHL); Total	X	X
Childhood Immunization Status (CIS); Combination 3	X	
Colorectal Cancer Screening (COL); Total	X	X
Follow-Up After Emergency Department Visit for Substance Use (FUA); 30 days, Total	X	X
Follow-Up After Hospitalization for Mental Illness (FUH); 30 days, Total	X	X
Follow-Up After Emergency Department Visit for Mental Illness (FUM); 30 days, Total	X	X
Glycemic Status Assessment for Patients with Diabetes (GSD); Glycemic Status <8.0%. *(formerly Hemoglobin A1c Control for Patients with Diabetes (HBD) and Comprehensive Diabetes Care (CDC))*	X	X
Initiation and Engagement of Substance Use Disorder Treatment (IET); Engagement of SUD Treatment - Total ages, Total drugs	X	X
Immunizations for Adolescents (IMA); Combination 2	X	
Lead Screening in Children (LSC)	X	
Plan All-Cause Readmissions (PCR); -Ages 18-64, Observed/Expected	X	X
Prenatal and Postpartum Care (PPC) - Postpartum Care - Timeliness of Prenatal Care	X	X
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	X	X
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	X	X
Well-Child Visits in the First 30 Months of Life (W30) -First 15 Months -15 Months-30 Months	X	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI percentile, Total - Counseling for Nutrition, Total - Counseling for Physical Activity, Total	X	
Child and Adolescent Well-Care Visits -Total (WCV)	X	

Public Posting of Quality Measures and Performance Outcomes

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

BadgerCare Plus (BC+) and Medicaid SSI HMO

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

Family Care and Partnership HMO

- External Quality Review Organization Annual Technical Report: Family Care, Family Care Partnership, and PACE: External Quality Review Activities - Includes Performance Improvement Project validation, Compliance with Standards, Performance Measure Validation, care management record reviews, and Information Systems Capabilities Assessments
- National Core Indicators:
  - National Core Indicators Project: Adult Surveys Overview
  - Results are available:
    - WI reports for National Core Indicators – In Person Survey (NCI-IPS) surveys for individuals with Intellectual and Developmental Disabilities
    - National Core Indicators – Aging and Disability (NCI-AD) report for Wisconsin
- Wisconsin Satisfaction Survey: Family Care: Program Monitoring and Evaluation
- Family Care and Partnership Scorecards: This includes MCO staff turnover rates, star ratings for how satisfied other members are with the MCO, and star ratings for how well the MCO follows state quality standards.
  - 2024 Scorecard Guide for MCOs, P-02484-24 (PDF)
  - 2024 Family Care MCO Scorecard, P-02553-24 (PDF)
  - 2024 Family Care Partnership MCO Scorecard, P-02554-24 (PDF)
- Pay-for-Performance Information is under the drop down “Quality Reports.”

Care4Kids

- External Quality Review Organization Annual Technical Report - Includes Performance Improvement Project validation, Compliance with Standards, Performance Measure Validation, Care4Kids care management record reviews, and Information Systems Capabilities Assessments.

- Care4Kids' parent health plan, Chorus Community Health Plan, is NCQA accredited.

Performance Improvement Projects and Interventions

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

BC+ and SSI HMO

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

Table 6: Suggested HMO PIP Topics

Clinical	Non-Clinical
Adolescent immunizations	Access and availability of services
Antidepressant medication management	Care coordination
Asthma management	Implementation of Culturally and Linguistically Appropriate Services (CLAS) Standards
Behavioral health and substance abuse screenings and management	Member satisfaction and experience of care
Blood lead testing	Social determinants of health
Breast cancer screening	SSI Care Management

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

Clinical	Non-Clinical
Childhood immunizations	Trauma-informed care
Childhood obesity interventions	
Dental care	
Diabetes management	
Emergency department utilization	
Health outcome improvements in chronic conditions, preventative care, primary care, behavioral health, etc. through care team extensions (for example, community health workers, doulas, health coaches, etc.)	
Hypertension management	
Prenatal and postpartum depression screening and follow-up	
Preventable hospital readmissions	
Tobacco cessation	
Well-child visits	

BC+ and SSI HMO Performance Improvement Projects (PIPs) for MY 2021-2024 can be found on the DHS website.

Family Care and Partnership MCOs

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

- Quality of care (for example, chronic conditions, palliative or hospice care, advance care planning)
- Chronic care self-management (for example, diabetes, heart disease, including hypertension)
- Behavioral health conditions (for example, anxiety disorders, depression)
- Trauma-informed care (for example, quality improvement of education processes and care capacity on multiple levels – MCO staff, members, providers, provider staff; effects of the pandemic)
- Access to preventive health (for example, adult vaccinations, mammograms, colonoscopies, regular primary care visits and follow-up, use of technology for health care access)
- Access to behavioral health resources (for example, utilization of existing behavioral health resources; use of technology resources)
- Access to mental health screening and/or self-care resources, mobilization of mental health first aid, access to/use of technology resources
- Access to community participation (for example, access to community-based recreation, exercise, volunteer opportunities, social groups, access to/use of technology resources)
- Access to or satisfaction with caregiver supports (for example, respite care, behavioral/mental health supports, member satisfaction)
- Quality of provider and provider staff supports (for example, COVID recovery, mental health, provider services to members)

Family Care and Partnership MCO Performance Improvement Projects (PIPs) for MY 2021-2024 can be found on the DHS website.

Care4Kids

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

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

PIP Topic	PIP Aim	PIP Interventions
Timely Completion of Initial Comprehensive Health Exam (ICHE) Letter	Increase the percentage of newly enrolled children who received an ICHE and had an ICHE letter shared with the primary care provider prior to the appointment from 53% to 80%.	• Increase monitoring of dates for ICHEs and letters. • Review medical records of new enrollees to ensure the ICHE letter is sent before exam. • Adjust the staffing model to a single health care coordinator to mitigate miscommunication. • Conduct chart reviews to verify the ICHE occurred and the ICHE letter had been sent.
Increased COVID-19 Vaccination Rate for Adolescents	Increase the percentage of children above the age of 12 years who are fully vaccinated with an authorized COVID-19 vaccine from 23% to 27%.	• Use electronic medical record to prompt conversations during outreach and enable outcome tracking. • Partner with child welfare and biological parents/legal guardians to obtain consent and share resources. This includes communication with youth when age appropriate to provide information and resources. • Continue to collaborate with community partners to increase movable vaccine clinics in targeted zip codes of underserved communities.
Decrease Access to Care Barriers for Not Timely Initial Comprehensive Health Exam Completion and Increased Care Coordination Efforts	Decrease the percentage of Initial Comprehensive Health Exam (ICHE) barriers related to access from 46% to 35% for all newly enrolled children in Care4Kids.	• Identify and implement best practice for ICHE tracking and addressing barriers to timeliness: o Earlier appointment offered but caregiver or child welfare professional could not bring youth. o Provider unavailable for an earlier appointment. • Change how information is communicated when providers move practices.
Increase Mental Health Assessments After a Mental	Increase the percentage of Care4Kids members who have an outpatient visit with a mental health	Care4Kids internal behavioral health therapist communicates with the in-patient team when a member is admitted to and discharged from a mental health

PIP Topic	PIP Aim	PIP Interventions
Health In-patient Hospitalization	provider within 30 days of a mental health in-patient hospitalization.	facility to ensure that the member receives the appropriate outpatient service once back in the community.
Increase Legal Guardian Information Sharing and Communication to Increase Birth to 3 Referral Completion	With outreach from a healthcare coordinator, utilizing DMS-developed materials about the Birth to 3 Program, to the parents/legal guardians, within 30 days of a positive developmental screen, increase successful referrals to the Birth to 3 Program for children in Care4Kids who are under 3. A successful referral from Care4Kids to the Birth to 3 program is achieved when a biological parent/legal guardian says yes to the Birth to 3 program evaluation.	Healthcare coordinator outreach to parents/legal guardians utilizing DMS-developed materials about the Birth to 3 Program. Outreach is defined as direct contact, phone conversation, virtual meeting, or face-to-face meeting.
Decreasing Rate of Emergency Room Visits for Children Classified as "High Utilizers"	Conduct case staffing with the Care4Kids team (healthcare coordinator, supervisor, and lead) on a child who has two ER visits or more (to preempt the child meeting a threshold for criteria of a "high utilizer" of four or more visits to the ER) result in a decreased rate of emergency room visits from 2.5% in MY 2022 to or below 1.75% in MY 2024, for all members enrolled in Care4Kids.	• Conduct case staffing to review member's care plan and collaborative discussion regarding any member needs and identifying additional resources. • Each member will receive appropriate care coordination following the case staffing to address any barriers and provide education on available resources. • Individualize response according to member needs including considerations for education needs, medical conditions, cultural, religious, and/or any language barriers.

Transition of Care Policy

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

BC+ and SSI HMO

- At the time of enrollment:

- DMS shares available Medicaid claims, encounter, and prior authorization data with a member's HMO to assist with care coordination. All HMOs are required to submit approved prior authorization data to DMS monthly to assist with this process.
- DMS requires HMOs to ensure continuity of care for members receiving health care and services under fee for service prior to their enrollment in the HMO and for newly enrolled members switching HMO enrollment.
- HMO ensures members have access to an in-network provider list.

- During enrollment:
  - HMOs must ensure members receive continued access to previous services when the absence of continued services would pose serious health or hospitalization, which includes the following:
    a. Provide continued access to services consistent with previous access levels.
    b. Authorize coverage of Medicaid services with the member's current provider for the first 90 days of enrollment.
    c. Authorize approved prior authorizations at the utilization level previously authorized for 90 days. Exceptions to the 90-day requirement will be allowed in situations where the member agrees to change providers, the member agrees to a lower level of care, or if the HMO can document that continuing the care would result in abuse, safety, or quality concerns.
    d. Have a detailed automated system for collecting all information on member contacts by care coordinators, case managers, and any other staff that has a direct impact on the member's access to services.
  - HMOs must coordinate services to the member between settings of care including appropriate discharge planning for short-term and long-term hospital and institutional stays. HMOs ensure continuity of care including completing medication reconciliation, ensuring members have a comprehensive understanding of their treatment plan, and assisting members with scheduling follow-up appointments with their primary care provider or specialists as needed after a member is discharged from an emergency department, hospital, nursing home, or rehabilitation facility.
  - HMOs must participate in Wisconsin Statewide Health Information Network (WISHIN) to facilitate exchange of medical records between health plans and providers. This includes subscribing to the WISHIN Pulse community health record, submitting a member roster as specified by WISHIN, and subscribing to the WISHIN Patient Activity Report (PAR). SSI HMOs must submit member care plans.
  - HMOs are required to provide any additional care management assistance to members with specific conditions or circumstances as needed or requested. This includes the following:
    a. Members receiving crisis or other intensive behavioral health services when transitioning back to in-network community settings.
    b. Members receiving obstetric medical home care management when transitioning to post-partum and pediatric care.
    c. Between settings transitions for those participating in the HIV/AIDS Health Home.
    d. SSI members (elderly, blind, or disabled adults) after a discharge from a hospital or facility stay.
    e. Coordination with school-based services to assure continuity of care during school breaks.
  - HMOs that identify a member with a special health care need are also required to share that information if the member transitions to another health plan or has other coverage, to avoid duplication of services.

- Disenrollment:
  - HMOs must assist members who want, and are eligible, to disenroll by making appropriate referrals and by assisting in the transfer of medical records to new providers.

Family Care and Partnership MCO

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

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

Care4Kids

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

- Upon enrollment in Care4Kids:
  - Ensuring continuity of care for members previously receiving care via fee-for-service Medicaid (FFS MA) or an HMO utilizing member-specific information provided by DMS, including claims/encounter history, prior authorizations, and upcoming non-emergency medical transportation trips.
  - Obtaining information from medical providers.
  - Ensuring access to the appropriate providers in the PIHP's network.
- During enrollment:
  - Coordination with school-based services to assure continuity of care during school breaks.
- Disenrollment:
  - The PIHP is responsible for facilitating the transfer of medical records to ensure continuity of care when a member switches health plans, providers, moves out of the Care4Kids service area, or is placed in a Residential Care Center
  - The PIHP engages in transition planning prior to the child leaving the medical home. Transition plans are developed with input from the child, their family, and the treatment team.
  - Transition activities include a final meeting with the treatment team and a successful transfer of medical records to new health plans and providers.
  - The PIHP shall assist members who return to the FFS MA system by making appropriate referrals and by assisting in the transfer of medical records to new providers, if necessary.
- Wisconsin Statewide Health Information Network (WISHIN)
  - Care4Kids is required to participate in WISHIN to facilitate the timely exchange of medical records between health plans and providers.

Plan to Eliminate Disparities

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

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

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

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

Current State Overview:

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

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

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

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

Table 8: Disparities Plan for 2025–2027

<table>
<tr><th rowspan="2">Managed Care Program</th><th colspan="5">IHI Improving Health Equity Framework</th></tr>
<tr><th>Make Health Equity a Strategic Priority</th><th>Build Infrastructure to Support Health Equity</th><th>Address the Multiple Determinants of Health</th><th>Decrease Institutional Racism</th><th>Partner with the Community to Improve Health Equity</th></tr>
<tr><td rowspan="4">BC+ and SSI HMOs</td><td colspan="5">• Maintain NCQA Health Equity Accreditation.
• Encourage HMOs to explore NCQA Health Equity Accreditation Plus, as additional effort to meet CLAS standards and increase community partnerships.</td></tr>
<tr><td colspan="5">Work toward incorporating all 15 National CLAS Standards into their organizational infrastructure by 2027.</td></tr>
<tr><td></td><td></td><td colspan="3">Design and implement performance improvement projects (PIPs) that address identified disparities in the populations the HMOs serve, building on improvement strategies implemented in previous PIPs.</td></tr>
<tr><td></td><td></td><td></td><td></td><td>Develop plan for involving members in Quality Improvement (QI) activities and soliciting member feedback in addition to their contractually required Member Advisory Council.</td></tr>
<tr><td>Family Care and Partnership MCOs</td><td>Demonstrate commitment to improving health equity at all levels of the MCO.</td><td>• Improve data collection and stratification capabilities to inform</td><td>Incorporate equity considerations into the topic selection, improvement strategies,</td><td>Expand requirements to foster equity and inclusion among MCO staff and providers.</td><td>Develop plan for involving members in QI activities and soliciting diverse member feedback in addition to</td></tr>
</table>

	For example, strategic planning efforts designed to reduce disparities, organizational self-assessment and training opportunities for all staff, etc.	future health equity efforts. • Incorporate National CLAS Standards into organizational practices and delivery of services by 2027.	and data analysis of all PIPs by 2027.		their contractually required Member Advisory Committee.
Care4Kids	• Maintain NCQA Health Equity Accreditation. • Explore NCQA Health Equity Accreditation Plus • Maintain National CLAS Standards within organizational infrastructure.	Improve data collection and stratification capabilities to inform future health equity efforts.	C4K will work with State partners to identify opportunities to connect children and their families to HRSN resources, particularly as the families approach reunification.	• Utilize the data from PIPs to identify racial health disparities and work together with DMS to develop action plans. • Review how staff demographic data compares to that of C4K's members.	Develop plan with Department of Children and Family partners for involving members in QI activities and soliciting member feedback.

DMS Activities

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

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

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

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

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

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

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

- Using results of the recent Obstetric Medical Home (OBMH) evaluation to improve this initiative's outcomes.
- Expanding partnership opportunities with other programs in the state with mutual goals to leverage resources and build additional capacity for improvement. Opportunities include:
  - Assisting the DHS Division of Public Health (DPH) Maternal Health Innovation Program with its efforts to address maternal mortality and morbidity inequities, including their Maternal Health Task Force and Maternal Mortality Review Team (MMRT).
  - Working with the Wisconsin Collaborative for Healthcare Quality (WCHQ) on ways DMS can partner with their Maternal Health Advisory Group on reducing disparities.
  - Participating in CMS' planned affinity groups for its Maternal and Infant Health Initiative.
  - Applied for the CMS Transforming Maternal Health program, and with award funding, DMS will accelerate and expand our current plans to eliminate maternal health disparities in our state.
  - Partnering with DPH in the implementation of the Wisconsin State Health Improvement Plan (SHIP).
- Continuing to demonstrate the need for Wisconsin to expand postpartum Medicaid eligibility coverage through outcomes data and member input.

Identification of Participants with Special Health Care Needs

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

BC+ and SSI HMOs

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

1. Children with serious emotional disorders
2. Children who have multiple significant chronic health problems that affect multiple organ systems and result in functional limitations
3. Members who are pregnant or who are 0 to 12 months postpartum

4. Members who have been incarcerated in the past 12 months
5. Members with a mental illness and another chronic condition (i.e. cardiovascular disease, diabetes, asthma)
6. Members who are homeless

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

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

Family Care and Partnership MCOs

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

Care4Kids

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

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

Network Adequacy and Availability of Services

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

BadgerCare Plus and SSI HMO

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

Organization analysis to determine the HMO's network adequately provides access, availability, and capacity to members.

Family Care and Partnership MCO

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

Partnership MCO

DMS must verify all Partnership MCOs are certified by CMS to meet adequacy standards for acute and primary care providers. This includes access to a women's health specialist, access to sufficient family planning services, and access to a second opinion from a qualified health care professional upon request.

Care4Kids

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

Clinical Practice Guidelines

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

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

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

BadgerCare Plus and SSI HMO

BadgerCare Plus and SSI HMOs must identify at-risk populations for preventive services and develop strategies for reaching members included

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

Family Care and Partnership MCO

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

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

Table 9: Clinical Practice Guideline Links by HMO/MCO

HMO	Link to Clinical Practice Guidelines
Anthem	https://providers.anthem.com/docs/gpp/WI_CAID_ClinicalPracticeGuidelinesMatrix.pdf
Chorus Community Health Plan (CCHP)	https://chorushealthplans.org/for-providers/clinical-and-preventative
Dean	https://deancare.com/providers/clinical-guidelines
GHC of Eau Claire (GHS-EC)	https://group-health.com/providers/quality-care-and-patient-safety

HMO	Link to Clinical Practice Guidelines
GHC of South Central Wisconsin (GHS-SCW)	https://ghcscw.com/members/badgercare-plus/
iCare	https://www.icarehealthplan.org/Education/Resources.htm
MercyCare	https://www.mercycarehealthplans.com/providers/behavioral-health-guidelines/ Password: MERCYDOCTORS https://www.mercycarehealthplans.com/providers/clinical-practice-guidelines/ Password: MERCYDOCTORS
MHS Health Wisconsin (MHS)	https://www.mhswi.com/providers/quality-improvement/practice-guidelines.html
Molina	https://www.molinahealthcare.com/molinaclinicalpolicy
Network Health Plan (NHP)	https://www.mhswi.com/providers/quality-improvement/practice-guidelines.html
Quartz	https://quartzbenefits.com/providers/provider-resources/provider-resources-clinical-guidelines/
Security Health Plan (SHP)	https://www.securityhealth.org/providers/tools-and-resources/clinical-practice-guidelines
UnitedHealthcare (UHC)	https://www.uhcprovider.com/en/policies-protocols/clinical-guidelines.html

Family Care and Partnership MCO	Link to Clinical Practice Guidelines
Community Care	*https://www.communitycareinc.org/providers/current-providers/practice-guidelines* *Also located under "Members," redirecting to the same link.*
iCare including Inclusa	https://www.icarehealthplan.org/Education/Resources.htm
Lakeland Care	Forms and Materials | Lakeland Care Provider Network (lakelandcareinc.com)

Molina, aka My Choice WI	https://mychoicewi.org/providers/resource-library/?wpv-resource-type=guideline&wpv_aux_current_post_id=281&wpv_aux_parent_post_id=281&wpv_view_count=318

Care4Kids

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

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

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

Performance Monitoring and Intermediate Sanctions

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

BadgerCare Plus and SSI HMO

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

DMS maintains the right to impose sanctions and financial penalties outside of the standards found here or to adjust penalties based on distinct situations or updated benchmarks. The chart below outlines three levels of performance tiers (minor, moderate, and major) with a corresponding description of enforcement actions. DMS maintains the right to impose sanctions without following the prescribed scheme at any time, including financial penalties, as provided under the BC+ and Medicaid SSI HMO Contract. Financial penalties can be imposed separately or in addition to the outlined sanctions below at the discretion of DMS.

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

Table 10: HMO Intermediate Sanctions

	Provider Network	Member Screening	Goal 1, Objective 1 HEDIS Measures	ACT
Examples of Minor Problems	One or more identified inadequacies in HMO's service area	Below established benchmarks	• One year with 51% to 79% of measures below the National HEDIS Median (NHM)	Final score between 58 – 79.9%
Enforcement	• Conditional certification • Formal impact reporting • Geoaccess report	• Request for information • Remediation	• Request for information • Remediation	• Request for information • Remediation
Examples of Moderate Problems	More than two identified inadequacies in HMO's service area and inadequate ratio and/or HMO provider network data issues	Below established benchmarks for more than 1 year	• One year with 80% or more of measures below the NHM • Three consecutive years or three years within a five-year period with 51% to 79% of measures below the NHM	Final score between 58-79.9% for two years
Enforcement	Any of the above, and: • Corrective action plan • Allow members in problem service area(s) to voluntarily disenroll from HMO	Any of the above, and: • Corrective action plan	Any of the above, and: • Corrective action plan • Suspend auto assignment	Any of the above, and: • Corrective action plan • Suspend auto assignment
Examples of Major Problems	Provider network inadequacies or inadequate ratios that continue over six	Below established benchmarks for more than two years	• Three consecutive years or three within the last five years with 80% or more of measures below the NHM	Final score below 57% in one year, or below 80% for three years

	Provider Network	Member Screening	Goal 1, Objective 1 HEDIS Measures	ACT
	months, and/or access issues for members		• Four consecutive years or four years within the last five years with 51% to 79% of measures below the NHM	
Enforcement	• Any of the above and: • Suspend auto assignments in problem service area(s) • Suspend all future enrollment in problem service area(s), and/or move current members into another HMO of the member's choice • Decertification in affected service areas	• Any of the above, and: • Suspend all new enrollment (voluntary and auto assignment) • Corrective action with public notification	• Any of the above, and: • Suspend all new enrollment (voluntary and auto assignment) • Contract termination	• Any of the above, and: • Suspend all new enrollment (voluntary and auto assignment) • Corrective action with public notification • Contract termination

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

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

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

ACT: Corrective Action (Remediation)

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

Family Care and Partnership MCO

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

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

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

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

When DMS becomes aware of any potential failures of an MCO to meet any of its performance expectations under federal or state law or the contract, DHS initiates an investigation to determine if any failures have occurred. If DHS determines that a sanction is warranted, it will determine which sanction(s) will be imposed and then informs the MCO and CMS (within 30 days) via written notices describing the nature and bases of the sanction and any due process protections that DHS elects to provide the MCO.

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

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

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

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

External Quality Review Arrangements

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

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

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

Table 11: Review activities conducted by MetaStar

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

After the EQRO completes the annual technical reports with program strengths and identifies recommendations for improvement, DHS shares results

with the managed care plans, posts the reports publicly, and determines if any program changes or remediation are needed as a result of these findings.

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

MetaStar completed a crosswalk comparing the Code of Federal Regulations to the NCQA health plan accreditation requirements identifying gaps not evaluated through accreditation. MetaStar reviews documents from the organizations to evaluate compliance with the identified gaps. The crosswalk is located on the DHS website (Quality for BadgerCare Plus and Medicaid SSI). Below are the reviews conducted by program.

Table 12: EQR reviews conducted by program

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

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

Appendix

Glossary

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

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

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

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

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

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

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

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

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

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

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

Consumer Assessment of Healthcare Providers and Systems®: A series of patient surveys created by The Agency for Healthcare Research and Quality (AHRQ) rating health care experiences, cover topics important to consumers, and focus on those aspects of quality that consumers are best qualified to assess.

Culturally and linguistically appropriate services standards: The national culturally and linguistically appropriate services standards are a set of fifteen action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. For more information, see Culturally and Linguistically Appropriate Services - Think Cultural Health (hhs.gov).

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

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

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

- **Frail Elder:** an individual who is 65 years of age or older and has a physical disability or irreversible dementia that restricts the individual's ability to perform normal daily tasks or that threatens the capacity of the individual to live independently.
- Children's PIHP: For Care4Kids, it means whether the individual qualified for Medicaid on the basis of a disability.

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

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

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

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

Fee-for-service: Fee-for-service is a payment method in which doctors and other health care providers are paid for each service performed. Individuals enrolled in Medicaid programs may receive some of their services on a fee-for-service basis outside their managed care program.

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

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

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

- Comprehensive care management

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

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

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

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

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

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

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

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

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

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

Managed care: Managed care systems integrate the financing and delivery of health care or long-term care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care or long-term care providers; have financial incentives for members to use providers and follow procedures associated with the plan; and have formal programs for quality, medical management, and the coordination of care. Managed Care contracted entities can include Health Maintenance Organizations (HMOs), Managed Care Organizations (MCOs), and Prepaid Inpatient Health Plans (PIHPs).

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

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

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

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

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

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

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

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

Pay-for-performance (P4P): Pay-for-performance is a term that describes payment systems that offer financial rewards to plans or providers who achieve, improve, or exceed their performance on specified quality measures, as well as other benchmarks. Although programs can take a number of different forms, pay-for-performance models are based on a common set of design elements:

- Performance measurement
- Incentive design
- Transparency and consumer engagement

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

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

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

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

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

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

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

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

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

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

people live.

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

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

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

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

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

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

Managed Care Quality Strategy Public Comments

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

- Presentation to advisory committees and councils.
- Presentation to the Medicaid Advisory Committee on September 4, 2024. Meeting notes are available on the Department of Health Services (DHS) website.
- Tribal nation consultation on September 11, 2024, at the Wisconsin Tribal Health Directors Meeting. There are 11 federally recognized tribes in Wisconsin, and tribal members may enroll in each managed care program.
- Publication on the DHS website.
- Email notice to partners, providers, and advocacy organizations.

Feedback from the public comment period was reviewed by DHS for consideration in revising the Quality Strategy. Following are the themes represented within the 26 comments received:

- Theme 1 – Suggestions to add objectives and/or metrics.
- Theme 2 – Suggestions to reduce objectives and/or metrics.
- Theme 3 - Specific clarifications or corrections of verbiage regarding goals, objectives, measures, targets, sanctions, and definitions.
- Theme 4 – Considerations for how to implement the goals, objectives, measures, targets and sanctions.
- Theme 5 – Geographic considerations for setting goals, objectives, measures, and targets.
- Theme 6 – Suggestions that the established goals, objectives, measures, targets, and sanctions were too numerous, burdensome or not achievable within the timelines.
- Theme 7 – Suggestions for DHS to consider within the Medicaid Program, but not directly applicable to the Quality Strategy.