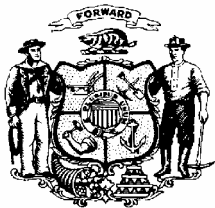# Strategic Plan
2006—2008

MEDICAID/BADGERCARE
Managed Care Program

S t a t e   o f   W i s c o n s i n

DEPARTMENT OF HEALTH AND FAMILY SERVICES
DIVISION OF HEALTH CARE FINANCING
BUREAU OF MANAGED HEALTH CARE PROGRAMS

Prepared by Gary R. Ilminen, RN
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October 2006

Quality Assessment and Performance Improvement

Strategic Plan 2006-2008 QAPI HMO
program__2 Gary R.Ilminen, RN

Strategic Plan Summary 2006—2008

Quality Assessment and Performance Improvement

Wisconsin Medicaid/BadgerCare HMO Program

Gary R. Ilminen, RN Nurse Consultant, BMHCP   October 2006

Strategic goals

Program goals for enrollees--

       Access to primary and specialty care is assured.
       Cultural and health care needs—including special needs—are identified and met.
       Quality of care provided meets or exceeds professional standards.
       Satisfaction with access and quality of care is high.

Program goals for participating HMOs

       Each HMO has an effective internal QAPI program.
       Each HMO has appropriate data capacity for encounter data, QAPI, etc.
       Each HMO performs effective outreach & enrollee education.
       Care management decisions are evidence-based.
       Duplicative non-care administrative QAPI functions and costs are avoided.

Program goals for DHFS

       All of the above are achieved and sustained in a cost-effective manner.
       Performance is accurately assessed
              Clinical performance measures
              Satisfaction performance measures
       Tactical tools are developed and used to drive performance improvement
              Across the HMO program
              On a program-specific basis
              On an HMO-specific basis
       QAPI strategy is dynamic, changing in response to evolving program needs
       Compliance with applicable federal requirements is achieved.

Key Elements of the QAPI Strategy

Performance-based contract
       Defines roles, structure and process
       Includes QAPI program, access and other requirements
       Includes data system, encounter data and reporting requirements
       Enforcement tools-intermediate sanctions up to termination
To view the HMO contract, go to:
http://www.dhfs.state.wi.us/medicaid7/providers/index.htm

Performance Assessment
       Clinical performance assessment tools—
              MEDDIC-MS clinical performance measures
              HMO performance improvement projects
              Grievance data on denials based on medical necessity
              HMO performance metrics

       Non-clinical performance assessment tools—
              Enrollee satisfaction survey
              Grievance & complaint data on non-clinical issues (access, rights, etc.)
              Disenrollment rates
              Encounter data validity audit (DVA)
              External Quality Review (EQR)
              DHFS Strategic plan and biannual strategic plan assessment

Performance improvement tools
       Transparency: public reporting of HMO-specific results on MEDDIC-MS
       MEDDIC-MS Goal-setting Process
       Care Analysis Projects
       Best practices symposium for sharing innovation
       HMO Report Card
       New Enrollee Health Needs Assessment (NEHNA) survey
       Stay Safe & Healthy enrollee safety education initiative
       External Quality Review
       Technical assistance, training
       Biannual QAPI recertification audit reports
       HMO performance improvement projects
       Contract enforcement—intermediate sanctions, suspension of enrollment,
              financial penalties, loss of accreditation incentive, etc.

Pay-for-performance and other incentives (Note: incentives under development may or may not be implemented based on management review, testing and program needs).
       HMO Accreditation Incentive Program
       EPSDT Prospective Payment Incentive
       Dental Care Performance Improvement Incentive (in implementation phase)
       Blood Lead Toxicity Screening Incentive (in implementation phase)
       Healthy Birth Outcomes Incentive (under development)
       Tobacco Cessation Program Incentive (under development)

Structure and process tools in contract (subject to certification and recertification review)
       Written HMO access and availability standards
       HMO written assurance of network adequacy
       Geo-access review of HMO provider network
       Coordination and continuity of care policies
       UM/UR, denial criteria and policies
       Clinical practice guidelines; development, update and dissemination policies

Enrollee rights protections and policies
Medical records content and confidentiality protections and policies
Enrollment and disenrollment policies
Grievance and complaint policies
Internal advocate and grievance processes, formal and informal
Delegation and oversight policies and agreements
Demand management system (nurse line or phone triage) policies
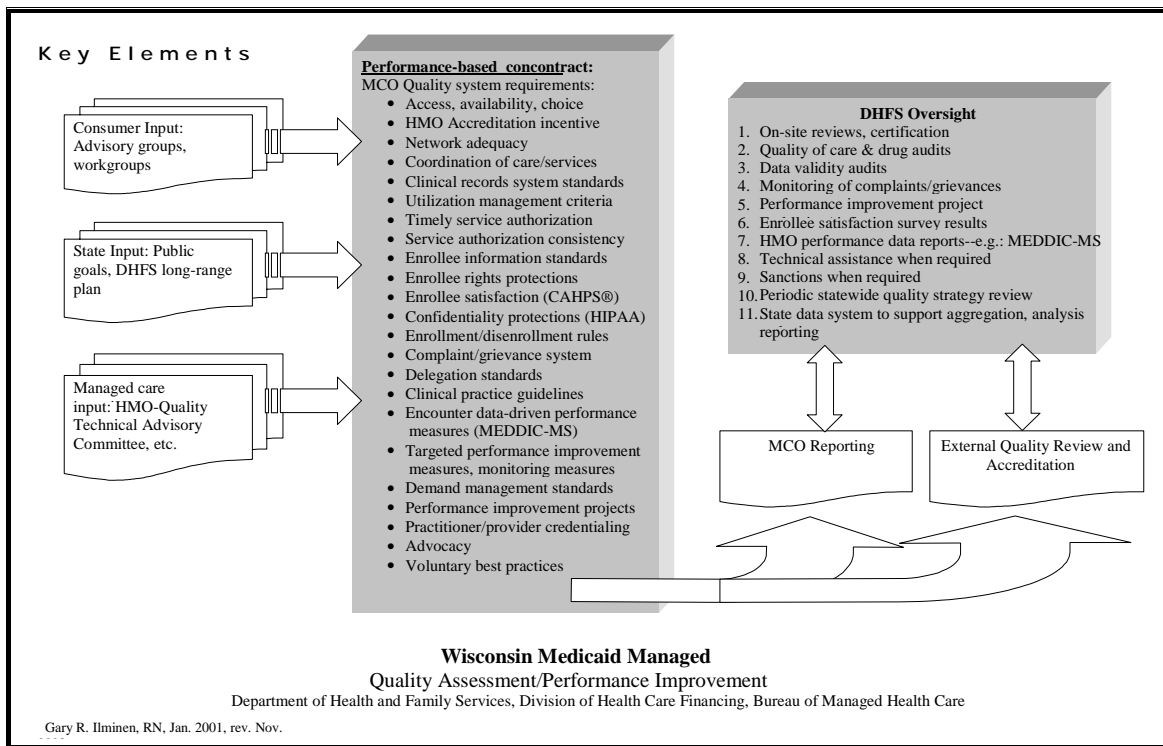Provider/practitioner credentialing/recredentialing policies

DHFS Oversight activities & tools
Certification and recertification audits
Quality of care audits (internal & external)
Encounter data validity audits
MEDDIC-MS & MEDDIC-MS SSI clinical performance measures
Health plan performance metrics
Complaint & grievance monitoring, audits and follow-up
External quality review

DHFS QAPI working groups
DHCF QAPI Strategic Planning Committee
HMO-QTAC (Quality Technical Advisory Committee)
Ad-hoc committees as needed.

Key elements of the Wisconsin Medicaid/BadgerCare HMO program quality assessment and performance improvement strategy
Medicaid/BadgerCare HMO Program QAPI Strategy in Operation

Key Elements

Performance-based concontract:
MCO Quality system requirements:
- Access, availability, choice
- HMO Accreditation incentive
- Network adequacy
- Coordination of care/services
- Clinical records system standards
- Utilization management criteria
- Timely service authorization
- Service authorization consistency
- Enrollee information standards
- Enrollee rights protections
- Enrollee satisfaction (CAHPS®)
- Confidentiality protections (HIPAA)
- Enrollment/disenrollment rules
- Complaint/grievance system
- Delegation standards
- Clinical practice guidelines
- Encounter data-driven performance measures (MEDDIC-MS)
- Targeted performance improvement measures, monitoring measures
- Demand management standards
- Performance improvement projects
- Practitioner/provider credentialing
- Advocacy
- Voluntary best practices

Consumer Input: Advisory groups, workgroups

State Input: Public goals, DHFS long-range plan

Managed care input: HMO-Quality Technical Advisory Committee, etc.

DHFS Oversight
1. On-site reviews, certification
2. Quality of care & drug audits
3. Data validity audits
4. Monitoring of complaints/grievances
5. Performance improvement project
6. Enrollee satisfaction survey results
7. HMO performance data reports--e.g.: MEDDIC-MS
8. Technical assistance when required
9. Sanctions when required
10. Periodic statewide quality strategy review
11. State data system to support aggregation, analysis reporting

MCO Reporting

External Quality Review and Accreditation

Wisconsin Medicaid Managed
Quality Assessment/Performance Improvement
Department of Health and Family Services, Division of Health Care Financing, Bureau of Managed Health Care

Gary R. Ilminen, RN, Jan. 2001, rev. Nov.

Performance Assessment

"You can't manage what you can't measure." W. Edwards Deming

Clinical performance assessment tools—

MEDDIC-MS clinical performance measures (Family Medicaid/BadgerCare and MEDDIC-MS SSI (iCare) Ref. *42 CFR §438.240(c)(2)*

Frequency/timing: Annual and as needed, based on program needs.

Wisconsin's HMO program QAPI strategy includes a unique set of performance measures designed to cost-effectively meet changing program needs. It is called MEDDIC-MS, the Medicaid Encounter Data Driven Improvement Core Measure Set. A companion system designed specifically for the SSI population is in use for iCare.

MEDDIC-MS reduces the cost of performance measurement by eliminating some high cost non-care administrative functions associated with other measure systems. For example, paper medical record review has been eliminated except for uses such as encounter data validity audits and focused quality reviews. It also eliminates all HMO self-reporting of performance measure data. It includes measures on primary care,

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specialty care, inpatient care, outpatient care, mental health, substance abuse, preventive care including childhood immunizations, EPSDT and blood lead toxicity screening, women's health and maternity measures, chronic conditions such as diabetes and asthma, and dental care including preventive care and general dental services.

In 2003, the MEDDIC-MS and MEDDIC-MS SSI performance measures were evaluated by the Agency for Healthcare Research and Quality (AHRQ) and accepted for inclusion in the National Quality Measures Clearinghouse (NQMC®).

To view the measure summaries on the NQMC, go to http://www.qualitymeasures.ahrq.gov/browse/measureindex.aspx and scroll down to "State of Wisconsin."

In 2005, both systems were selected as finalists in the Council of State Government's Innovation Award program and as semi-finalists in the Innovations in American Government Award program sponsored by Harvard University's John F. Kennedy School of Government. Also, in 2005 both systems were selected as "Transforming Examples" in American healthcare by the Center for Health Transformation. See the CHT website for more information at:
http://www.healthtransformation.net/Transforming_Examples/Transforming_Examples_Resource_Center/1599.cfm

In 2006, URAC® reviewed and approved MEDDIC-MS and MEDDIC-MS SSI for its health plan accreditation program. MEDDIC-MS SSI is the first managed care measure set for use in the SSI population to gain approval by a national accreditation body.

To view public reporting of the results on MEDDIC-MS and MEDDIC-MS SSI measures online, go to:
http://www.dhfs.state.wi.us/medicaid7/providers/index.htm

MEDDIC-MS includes a feature not found in any other performance measure system, public or private: a data-driven performance improvement goal-setting mechanism. This allows the DHFS to target areas of clinical performance most in need of improvement on an individual HMO level. Performance goals are set using the U.S. DHHS "performance gap" formula found in QISMC (the Quality Improvement System for Managed Care) and actual prior year HMO performance data on the measure.

This approach facilitates setting realistic, achievable goals, instead of adapting arbitrary and unrealistic goals based on broad policy objectives instead of actual data. It allows the DHFS to "ramp up" program-wide performance one HMO at a time.

HMO performance improvement projects *Ref. 42 CFR §438.240(d)*

Frequency/timing: Annual.

The Wisconsin Medicaid/BadgerCare HMO and iCare contracts require each HMO to submit at least two performance improvement project reports annually. The DHFS' external quality review contractor exhaustively reviews the reports for accuracy, validity,

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and relevance. Additional projects may be required under the contract at the Department's discretion, when it deems performance improvement on a given topic is necessary. For example, performance improvement projects may be required when the MEDDIC-MS or MEDDIC-MS SSI data, enrollee satisfaction survey data or other information indicates the need for performance improvement.

In addition to providing performance improvement data on the topic of the specific project, these reports provide insight into the degree of capability and sophistication of the HMO's internal QAPI program. The reports reveal how well the HMO's staff, data systems and other assets are brought to bear to evaluate quality issues, develop improvement strategies and implement quality improvement initiatives.

To view a summary of HMO performance improvement project report topics, go to: http://www.dhfs.state.wi.us/medicaid7/reports_data/mcorgperimp.htm

Grievance data on denials based on medical necessity *Ref. 42 CFR §438.228*

Frequency/timing: Annual, on-going quarterly.

Tracking and analysis of grievances arising from HMO denials of clinical services based on medical necessity provides insight into HMO compliance with contract requirements affecting UM/UR systems, enrollee notification of adverse actions and its internal clinical decision-making capabilities.

The number of grievances brought by enrollees against an HMO may be an indicator of a problem with the HMO's UM/UR system. However, the rate at which the HMO's denials are ordered overturned by the DHFS provides a more accurate assessment of the degree of HMO understanding and compliance with state statutes and HMO contract requirements governing medical necessity and utilization management.

Non-clinical performance assessment tools—

CAHPS®[1] enrollee satisfaction survey *Ref. 42 CFR §438.10(i), 42 CFR §438.240(b)(1)*
Frequency/timing: Biannual.

Wisconsin has eliminated the requirement for satisfaction surveys by each individual HMO and replaced those duplicative surveys with one state-wide survey administered by an independent third party under contract to the DHFS. This has reduced overall quality assessment costs and improved reliability and consistency of data.

Since the survey is fairly lengthy and costly to administer, the DHFS has reduced the frequency of administration from annually to bi-annually. In addition, to further reduce non-care administrative costs, and improve actionability of the data, the DHFS is evaluating options for replacing CAHPS with a more precise, less lengthy survey tool.

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[1] CAHPS, the Consumer Assessment of Health Plans is a standardized enrollee satisfaction survey for managed care. CAHPS is a registered trademark of the Agency for Health Care Quality (AHRQ), a federal agency.

The results of the state's CAHPS surveys are publicly reported. To view the Executive Summary report of the most recent survey results, go to:
http://www.dhfs.state.wi.us/medicaid7/providers/index.htm

Grievance & complaint data-non-clinical (access, rights, etc.) *Ref. 42 CFR §438.228*

Frequency/timing: Annual, quarterly, on-going.

Tracking and assessment of complaints and grievances provides data for evaluation of HMO compliance with contract requirements affecting HMO customer service, internal advocacy, enrollee rights, telephone access, nurse triage lines, and so on. It also provides supplemental information for assessment of CAHPS data and clinical grievances and complaints.

Disenrollment rates *Ref. 42 CFR §438.226*

Frequency/timing: Annual, quarterly, on-going.

Tracking and assessment of disenrollment rates and trends can provide supplementary information for HMO performance in customer service, clinical service, UM/UR and satisfaction.

Encounter data validity audit (DVA) *Ref. 42 CFR §438.242*

Frequency/timing: Annual.

Encounter data validity audits are performed by the DHFS with support from the EQRO. The audits assess the accuracy and completeness of each HMO's clinical encounter data. The DVA is performed on varying clinical topics on half of the participating each year, allowing a rotation of targets.

External Quality Review (EQR) *Ref. 42 CFR §438.240(d)*

Frequency/timing: Annual.

The primary focus in the external quality review (EQR) process is on implementation of CMS EQRO Protocol #1, determining MCO/PIHP compliance with federal Medicaid managed care regulations. Other EQR activities include implementation of CMS EQRO Protocol #2, Validation of performance measures and Protocol #3, validation of performance improvement projects undertaken by an MCO/PHP.

The implementation of Protocol #2 involves internal activities only, since HMOs do not calculate or report any performance measures under the MEDDIC-MS system. This

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reduces administrative cost and prevents duplication. Implementation of Protocol #3 is an on-going process, since the EQRO is already involved in detailed evaluation and validation of all HMO performance improvement projects.

HMO Report Card *Ref. 42 CFR §438.304(H) and 42 CFR §438.10(f)(2)(i-ii),. 42 CFR §438.218*

Frequency/timing: Annual.

The availability of comprehensive clinical performance reports and enrollee satisfaction reports enables informed choice by current and prospective enrollees. This information can enable individuals to make better-informed choices among the HMOs available in the area in which they live.

However, the large volume of complex performance data available to the DHFS for use in program management may not be suitable for such use by consumers. In order to make key information available to consumers in an easy-to-use form, the DHFS has created the **Medicaid/BadgerCare HMO Report Card.**

The HMO Report Card includes 9 indicators in all. MEDDIC-MS data are used for 5 clinical indicators and satisfaction survey data are used for 4 non-clinical indicators.

HMOs are compared to the program-wide average for HMO performance on each indicator in the Report Card. Each HMO is rated "below average" signified by one star (✷), "average" signified by two stars (✷ ✷), or "above average" signified by three stars (✷ ✷ ✷). The difference between ratings "below average," "average" and "above average" is statistically significant.

Publication is via addition to the Medicaid managed care website (see: http://www.dhfs.state.wi.us/medicaid7/providers/index.htm) and in the new enrollee informing materials packets.

The effectiveness of the HMO Report Card was assessed as part of the 2004 CAHPS Enrollee Satisfaction Survey. Of those respondents who indicated that they saw the Report Card, 73 percent indicated they found it helpful in choosing their first HMO or changing HMO.

Performance improvement tools

MEDDIC-MS Goal-setting Process

See the entry for MEDDIC-MS under "Clinical Performance Assessment Tools" above.

Care Analysis Projects

Frequency/timing: Quarterly.

In 2001, the Department implemented an innovative program-wide proactive approach to performance improvement called Care Analysis Projects (CAP). Through CAP, enrollee-specific health care needs are identified and the data about those needs are shared with the enrollee's HMO. In this way, the Department seeks to assist in quality improvement by allowing HMOs and providers to focus outreach on individuals with unmet needs.

CAP focuses on several chronic conditions and on the provision of key preventive services. Chronic conditions included are congestive heart failure, asthma, and diabetes. Preventive health services include lead screening and prenatal risk assessment.

MEDDIC-MS and CAP work together. CAP provides data-driven targeted intervention and MEDDIC-MS allows accurate, rapid-cycle performance assessment.

Best practices symposium-fostering innovation

Frequency/timing: Annual.

The DHFS hosts an annual event known as the *Medicaid HMO Best Practices in Quality Improvement Symposium.* The symposium allows HMOs to share their experiences with what works and what doesn't in quality performance improvement with the Department, their peers and with the public.

HMOs are invited to participate based on the quality and results of their annual performance improvement projects. HMOs selected by the DHFS Chief Medical Officers are given the opportunity to present on their projects at the symposium. Through this process, the DHFS drives program-wide performance improvement through diffusion of innovation and more effective uses of technology.

Of 25 respondents completing the program evaluation form after the 2006 Symposium, 90 percent said the event provided new information that they would probably use in some quality improvement, policy development or health care delivery capacity. In addition, 80 percent said the information presented was "very useful," 20 percent said it was "somewhat useful."

New Enrollee Health Needs Assessment (NEHNA) survey *Ref. 42 CFR §438.208(b)(2)*

Frequency/timing: On-going.

Improving the health of Medicaid/BadgerCare enrollees is ultimate goal of the managed care program. To reach that goal, the HMO and its provider network must be able to conduct effective outreach to their enrollees and the HMO must identify and meet the care needs of their enrollees.

HMOs often report difficulty performing outreach with their enrollees because they relocate frequently, have unique cultural or language needs, and may lose their telephone service periodically or have none at all. In addition, there has been no mechanism to

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gather information about these issues or about health status or special health care needs at the point of enrollment.

In an effort to provide better information to HMOs, a tool called the New Enrollee Health Needs Assessment (NEHNA) survey was developed in 2001. The voluntary assessment is administered by phone and mail by the state's enrollment broker. The data is shared electronically with the new enrollee's HMO to alert it to special health care needs, facilitate improved outreach by identifying language and cultural needs, alternative contact information and improve linkage of enrollees to services. The survey and data-sharing process was implemented in January 2002.

Stay Safe & Healthy enrollee safety education initiative _Ref. 42 CFR §438.218_

Frequency/timing: On-going.

Since the release of an Institute of Medicine (IOM) report[2] in 1999, interest in the issue of patient safety in the U. S. healthcare system has continued to grow among consumers, practitioners, policy makers and legislators.

The last line of defense against a potential medical error or adverse event is the family caregiver/patient him or herself. The IOM addresses the importance of this fact:

"Well-informed patients are key participants in the effort to enhance the quality and safety of American health care. The right question from a patient at the right time may be the intervention that averts an error. Clearly, an ongoing, aggressive public information and education effort is needed to increase all Americans' understanding of both how medical errors occur and what steps they can take to prevent such errors."[3]

The DHCF contributes to safe care for Medicaid/BadgerCare recipients through a direct intervention targeted to consumers. The Stay Safe & Healthy educational outreach tool was developed to help enrollees be more effective partners with their health care providers in getting safer care for themselves and their family.

The Stay Safe & Healthy outreach tool is publicly available online and can be viewed at: http://www.dhfs.state.wi.us/medicaid7/recipients/stay_safe_healthy.htm

External Quality Review reports

See External Quality Review (EQR) above.

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[2] _Institute of Medicine, "To Err is Human: Building a Safer Health System,"_ LT Kohn, JM Korrigan, MS Donaldson, Eds. Washington, DC: National Academy Press, 1999.
[3] Report of the Quality Interagency Coordination Task Force (QuIC) to the President, Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact, February 2000.

<u>Technical assistance, training</u>

Frequency/timing: As needed.

The DHFS provides broad technical assistance to participating HMOs in the form of training sessions as well as targeted assistance and training for individual HMOs. Training and technical assistance may be provided by the DHFS or by its EQRO. Examples include technical assistance on data processing systems for encounter data, *Best Practices Symposium*, training on MEDDIC-MS and training on performance improvement projects.

<u>HMO recertification audit reports</u> *Ref. 42 CFR §438.202(c)(d)*

Frequency/timing: Pre-contracting and biannual thereafter.

Prior to participation and contracting, initial certification and bi-annual recertification of each HMO is conducted. Certification review includes detailed review of policies, procedures, annual reports and work plans for the HMO's QAPI program.

EQR reporting is used to review HMO QAPI program policies and procedures to assure compliance with applicable HMO contract provisions and federal requirements. HMOs that are privately accredited are reviewed under a special abbreviated process that eliminates duplication of oversight activities. See <u>HMO Accreditation Incentive</u> below.

<u>HMO performance improvement projects</u>

See <u>HMO performance improvement projects</u> on page 5.

<u>Strategic plan and biannual strategic plan assessment</u> *Ref. 42 CFR §438.202(a)(d)(e)*

Frequency/timing: Biannual.

Wisconsin's Medicaid/BadgerCare HMO program quality improvement systems are part of an overarching QAPI strategy. The strategic plan outlines the key elements of that strategy and how they work together as part of a coordinated system.

The Medicaid Managed Care Final Rule 42 CFR §438.202(a) requires that state Medicaid programs have a written QAPI strategy for their managed care programs. 42 CFR §438.202(d) requires that state Medicaid programs "periodically" review the effectiveness of their managed care quality assessment and performance improvement (QAPI) strategies. Also, 42 CFR §438.202(e)(1) requires that state Medicaid programs submit to the Centers for Medicaid and Medicare Services (CMS) "regular" reports on the effectiveness and implementation of the QAPI strategy.

Four strategic plan assessments have been conducted for the Wisconsin Medicaid HMO program, one in January 2000, the second in January 2002, and the third in January 2004, the fourth in January 2006. The CMS evaluated Wisconsin's written QAPI strategy in August 2003 and found it to be in substantial compliance with all applicable federal requirements.

Wisconsin conducts strategic plan assessments every two years. Where indicated, changes to the strategy are made and the results of the assessment are reported to the CMS.

Contract enforcement—intermediate sanctions, suspension of enrollment, financial penalties, loss of accreditation incentive, etc. *Ref. 42 CFR §438.204(e)*

Frequency/timing: On-going as needed.

The HMO contract contains options for the DHFS to use when contract provisions agreed to by the HMO are not met and remain unmet after the DHFS attempts to achieve voluntary compliance. The options range from warning/reminder letters to denial of new enrollments, financial penalties and termination of the agreement.

To view the HMO contract, go to
http://www.dhfs.state.wi.us/medicaid7/providers/pdfs/mc10051.pdf

HMO Accreditation Incentive Program *Ref. 42 CFR, §438.360*

Frequency/timing: Annual or as needed based on accreditation status.

Congress and the State of Wisconsin Department of Health and Family Services have recognized private accreditation of HMOs as an important part of a managed care performance improvement strategy.

The Balanced Budget Act of 1997 allowed States to not duplicate certain oversight activities that have already been completed by accredited managed care organizations. (Ref. 42 CFR, §438.360 Non-duplication of mandatory activities). The Wisconsin Medicaid/BadgerCare HMO contract allows certain regulatory relief for fully accredited HMOs.

The achievement of full accreditation by an accreditation body approved by the Department and satisfaction of the requirements of the HMO Accreditation Incentive Program as specified by the Department results in the HMO qualifying for the Accreditation Incentive.

The HMO Accreditation Incentive provides the following benefits to the HMO:

1. On-site external quality review activities related to HMO quality improvement program review by the department's EQRO may not be performed during the

period the accreditation is in effect. EQR activities with respect to certain mandatory and optional Protocols specified by HHS may be conducted at the Department's discretion.

2. Population health and service performance improvement projects reported for the HMO's accrediting body will be deemed acceptable for Medicaid/BadgerCare as long as they include Medicaid/BadgerCare enrollees. Proposals on the acceptability of HMO-wide performance improvement projects may be submitted for consideration by the Department on a case-by-case basis.

The HMO Accreditation Incentive is currently not available to any MCO seeking initial certification, since the MCO must first complete service in at one full contract cycle.

Pay-for-performance and other incentives

Dental Care Performance Improvement Incentive (in implementation phase)

The proposed incentive would focus on driving improvement in delivery of general and preventive dental services among HMOs that include dental services in their contract.

Blood Lead Toxicity Screening Incentive (in implementation phase)

Blood lead screening is a mandatory service for one and two year old children in Medicaid. Progress has been made by HMOs in the delivery of these services with rates of delivery improving each year since 2000 program wide. This proposed incentive would be designed to accelerate improvement.

Healthy Birth Outcomes Incentive (under development)

Prenatal and maternal care are high-value services provided under the Medicaid HMO contract. However, there is wide variation in the way the services are coordinated and delivered across HMOs. This proposed incentive would encourage the establishment of a comprehensive prenatal and maternal care program in each HMO.

Tobacco Cessation Program Incentive (in implementation phase)

Tobacco use remains a concern in the Medicaid program. Though tobacco cessation benefits are available to Medicaid HMO enrollees, the use of the benefits has been inconsistent. This proposed incentive would improve identification, outreach, and delivery of treatment services for tobacco cessation.

EPSDT incentive (implemented)

Early, periodic screening, diagnosis and treatment (EPSDT) services are mandatory for children in Medicaid. This incentive pays the health plan prospectively for EPSDT screening levels that meet DHFS performance goals and recoups funds if goals are not met.

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Structure and process tools-in contract (subject to certification and recertification EQR activity.)

The following elements are implemented through provisions in the contract.

>Written HMO access and availability standards
>HMO written assurance of network adequacy
>Electronic data on HMO provider network
>Coordination and continuity of care policies
>UM/UR, denial criteria and policies
>Clinical practice guidelines; development, update and dissemination policies
>Enrollee rights protections and policies
>Medical records content and confidentiality protections and policies
>Enrollment and disenrollment policies
>Grievance and complaint policies
>Internal advocate and grievance processes, formal and informal
>Delegation policies and agreements
>Demand management system (nurse line or phone triage) policies
>Provider/practitioner credentialing/recredentialing policies

DHFS Oversight activities & tools
>Certification and recertification audits
>Quality of care audits (internal & external)
>Encounter data validity audits
>MEDDIC-MS & MEDDIC-MS SSI clinical performance measures
>Health plan performance metrics
>Complaint & grievance monitoring, audits and follow-up
>External quality review

These strategic elements are described in more detail above.

DHCF QAPI working groups

DHCF QAPI Strategic Planning Committee (i.e.: the "quality committee")

This committee has broad representation from a variety of bureaus and sections within the Division of Health Care Financing. This committee provides input for design, maintenance and modification of the QAPI Strategic Plan.

The committee includes ad-hoc members, speakers and participants from outside the DHCF.

HMO-QTAC (Quality Technical Advisory Committee)

The HMO-QTAC meets every other month. It includes QAPI program representatives from all of the participating HMOs, non-HMO participants and several DHFS staff.

Principle areas covered are technical aspects of performance measures, HMO contract requirements, program-wide quality improvement initiatives and information exchange.

<u>Use of technology to improve public access to performance data</u>

There is an old adage in the quality improvement specialty which, with an added phrase describes Wisconsin's philosophy of comprehensive public reporting of program performance data:

"That which is measured improves—that which is measured, with the results publicly reported improves even more."

Wisconsin leverages the latest technology not only to acquire and analyze clinical and non-clinical performance data, but to make it readily available to the public. This is done through Internet reporting. By providing links to the correct pages on the Wisconsin Medicaid Managed Care website, it is possible to allow information seekers to quickly find the data that matches their interests and needs. The list of links is called the Wisconsin Medicaid Quality Quick Reference.

For your convenience, Wisconsin Medicaid/BadgerCare comprehensive quality performance data is on the Wisconsin Medicaid managed care website for quick reference. Here is the link:
http://www.dhfs.state.wi.us/medicaid7/providers/index.htm

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Wisconsin Medicaid/BadgerCare HMO Program QAPI Strategy
System Work flow
Gary Ilminen, RN Nurse Consultant 1-05

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