Wisconsin Department of Health Services (DHS)
Division of Medicaid Services

HMO Quality Guide

Measurement Year (MY) 2017

This Guide provides an overview of the measures, targets, methodology and operational details supporting DHS' HMO Quality initiatives for BadgerCare Plus and SSI.

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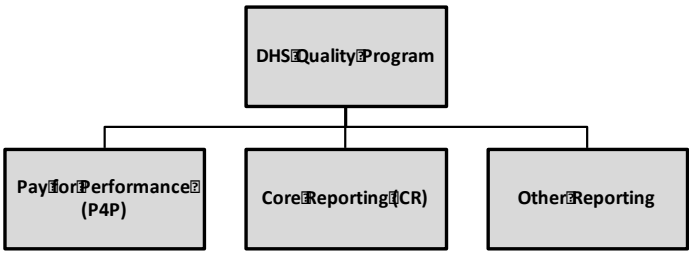
I. Measurement Year 2017 Overview

The quality initiatives of the Wisconsin Department of Health Services (DHS) include HMO Pay-for-Performance (P4P), Core Reporting (CR) and other reporting (e.g., related to specific initiatives) measures as shown below:



- The P4P initiative focuses on improving the measurable quality of care for Medicaid members. Its current scope includes Managed Care Organizations (MCOs, also referred to as HMOs), and applicable capitation withholds that can be earned back by HMOs based on their performance relative to quality targets for various measures applicable to them. These measures would relate to specific areas that DHS wants to emphasize, while balancing the total number of measures in P4P. DHS will continue its movement from Process-only measures to a combination of Process and Outcome measures - e.g., from HbA1c testing to HbA1c Control, related to diabetes care.
- The **CR** initiative focuses on providing DHS healthcare quality data for a broad set of conditions and related measures. It does not include a withhold though requires HMOs to report data on specific quality measures. Initially, non-reporting would result in flat penalties of $10,000 per measure. In future years, select Core Measures could also have performance targets based on state-wide performance compared with national benchmarks, with flat penalties ($10,000 per measure) for not meeting those targets.

  DHS plans to include results for all the above quality measures in its HMO Report Cards, including that for MY2016. Some measures may be calculated by the DHS' analytics vendor. The HMO Report Card is publicly available on the DHS website (www.forwardhealth.wi.gov).
- **Other Reporting** initiatives pertain to specific quality data related to other DHS programs such as SSI Care Management initiative, Health Needs Assessment, HealthCheck.

  Depending on the specific Medicaid members it serves, an HMO might participate in all Quality initiatives.

Measurement Year (MY) for the initiatives typically starts on January 1 and ends on December 31 of that calendar year, unless otherwise noted for specific initiatives.

II. Pay-for-Performance (P4P)

A. Scope

- **BC+:** Standard plan, including Childless Adults, in all 6 Regions
- **SSI** in all 6 Regions

Dual (Medicare) eligible members are excluded from BC+ and SSI P4P unless they meet enrollment requirements for Medicaid only during the year. Retroactive Medicare eligibility and enrollment are accounted for if such actions occur before the cut-off date for the data used for the Measurement Year (MY).

Performance targets and results for each measure and HMO will be set and calculated for all 6 Regions collectively, unless otherwise specified (e.g., for Dental measures in Regions 5 and 6).

B. Measures, Withhold and Targets

1. The DHS extensively uses HEDIS measures for its P4P initiative; please refer to HEDIS[1] Technical Specifications published by NCQA[2] for details of specific measures. Additional HEDIS-like measures supplement the HEDIS measures, as needed; these additional measures are described in this Guide.
    - **BC+**: Total of 14 measures (10 HEDIS, 4 HEDIS-like). Two of these 14 are Pay-for-Report (P4R) measures, i.e., HMOs will earn back their withhold for these two measures for MY2017 for simply reporting their verified HEDIS results, regardless of their performance.
    - **SSI**: Total of 9 measures (7 HEDIS, 2 HEDIS-like). Two of these 9 are Pay-for-Report (P4R) measures.
2. The 2017 upfront **withhold rate** is 2.5%, and will apply to all capitation for BC+ and SSI, including administrative payments. If the dental measures apply to an HMO, the withhold rate will be 2.5% of the dental capitation payment.

    Separate withhold % will apply individually to each measure. Each HMO will earn its withhold back for each measure, separately. The following table lists withholds associated with specific P4P measures for BC+ and SSI.

[1] Health Effectiveness Data and Information Set

[2] National Committee for Quality Assurance (http://www.ncqa.org), a private, 501(c)(3) not-for-profit organization

Medical Quality Measures and Withhold – 2.5% of medical capitation

Focus Area	MY2017 Measures	BC+ Withhold	SSI Withhold
Preventive / Screening	Breast Cancer Screen (BCS)	0.25%	0.30%
	Childhood Immunization (CIS) – Combo 3	0.25%	**N/A**
Chronic	Comprehensive Diabetes Care - HbA1c Test	0.25%	0.30%
	HbA1c Control (<8.0%) - Pay for Reporting. HEDIS measure, NQF # 0575	0.125%	0.15%
	Controlling BP (CBP) - Pay for Reporting. HEDIS measure, NQF # 0018	0.125%	0.15%
Mental Health & Substance Abuse	Depression Medication (AMM - Continuation)	0.25%	0.30%
	AODA (IET - Engagement)	0.25%	0.30%
	Tobacco (Counseling only) – non-HEDIS	0.25%	0.30%
	Follow-up after inpatient discharge (FUH30)	0.25%	0.30%
Pregnancy / Birth	Prenatal and Post-partum care (PPC) – 2 measures	0.125% + 0.125%	**N/A**
Emergency	ED Visits (AMB) sans revenue code 0456	0.25%	0.40%
	TOTAL	**2.5%**	**2.5%**

Dental Quality Measures (Regions 5 and 6 only) – 2.5% of dental capitation

Focus Area	MY2017 Measures	BC+ Withhold	SSI Withhold
Dental Care	Children (ADV + dental care provided by physicians); non-HEDIS	1.25%	**N/A**
	Adults (similar to children's measure except for age range and relevant codes); non-HEDIS	1.25%	**N/A**

3. The DHS utilizes NCQA's Quality Compass data for Medicaid and HMO-specific performance data as key inputs for setting two types of P4P targets:

   - **Level Targets**: Level targets are based on NCQA's Quality Compass (national Medicaid) percentiles, or State-wide averages, as applicable. The Level targets aim to reward HMOs that perform at high average levels. All HMOs have the same Level target for a measure.
   - **Reduction in Error (RIE) Targets**, also known as Degree of Improvement: The RIE targets require a baseline, established from past performance data. The RIE targets aim to reward HMOs that make significant improvements over time, even if their Level performance does not meet targets. The RIE methodology recognizes "diminishing returns" as performance improves, i.e., moving 5 percentage points from 65% to 70% is not the same as moving 5% percentage points from 85% to 90%. RIE targets are specific to each HMO for each measure, since they are based on the past performance of each HMO.

   MY2017 targets for BC+ and SSI for both, Level and RIE, are presented in the tables below.

MY2017 targets for BC+ and SSI

BC+ MY2017 P4P Targets													
MY2017 P4P Measures	**2015 WI Avg**	**NCQA percentiles (CY2015, aka HEDIS 2016)**						**Level Target**			**RIE Target**		
		25th	*33rd*	*50th*	*67th*	*75th*	*90th*	*High*	*Med*	*Low*	*High*	*Med*	*Low*
AMB - ED Visits (sans revenue code 0456)[3]	**58.99 visits**	53.2	**55.4**	62.8	70.2	73.3	87.6	<= 55.4 (33rd p'tile)	55.3 – 62.8	>=62.9	>= 5%	2%-4.9%	<=1.9%
AMM (continuation) - Depression Rx	**49.5%**	32.8	34.7	38.1	41.5	**43.4**	54.3	>=43.4% (75th p'tile)	38.1% – 43.3%	<=38%	>=5%	2%-4.9%	<=1.9%
Breast Cancer Screen (BCS)	**69.8%**	52.2	53.7	58.1	63.1	**65.3**	71.5	>=65.3% (75th p'tile)	58.1% - 65.2%	<=58.0%	>=10%	5%-9.9%	<=4.9%
CDC-HbA1c Test (Diabetes)	**91.9%**	83.0	84.1	86.0	88.1	**89.4**	92.9	>=89.4% (75th p'tile)	86.0% - 89.3%	<=85.9%	>=10%	5%-9.9%	<=4.9%
CIS - Childhood Immunization (Combo 3)	**74.2%**	64.3	67.1	71.1	73.7	**75.6**	79.8	>=75.6% (75th p'tile)	71.1% – 75.5%	<=71.0%	>=10%	5%-9.9%	<=4.9%
FUH-30 - Follow-up after MH inpatient discharge	**74.1%**	54.6	58.2	63.9	70.4	**72.6**	78.5	>=72.6% (75th p'tile)	63.9% - 72.5%	<=63.8%	>=10%	5%-9.9%	<=4.9%
IET Engagement - AODA	**11.6%**	6.9	8.0	9.6	11.9	**13.2**	16.9	>=13.2% (75th p'tile)	9.6% - 13.1%	<=9.5%	>= 5%	2% - 4.9%	<=1.9%
PPC – Prenatal care	**84.2%**	74.2	78.1	82.3	85.6	**87.6**	91.0	>=87.6% (75th p'tile)	78.1% - 87.5%	<=78.0%	>=10%	5%-9.9%	<=4.9%
PPC - Post-partum care	**67.7%**	55.5	57.1	61.0	66.0	**67.5**	73.6	>=67.5% (75th p'tile)	61.0% - 67.4%	<=60.9%	>=10%	5%-9.9%	<=4.9%
Tobacco (Counseling)[4]	**65.1%**	N/A	N/A	N/A	N/A	N/A	N/A	>=68.5%	63.3% - 68.4%	<=63.2%	>=10%	5%-9.9%	<=4.9%
Dental – Children	**44.0%**	41.4	**44.7**	51.7	57.3	60	65.9	>= 44.7% (33rd p'tile)	41.4% - 44.6%	<=41.3%	>=7%	4%-6.9%	<=3.9%
Dental - Adults[5]	**28%**	N/A	N/A	N/A	N/A	N/A	N/A	>=31%	25.1% - 30.9%	<=25.0%	>=7%	4%-6.9%	<=3.9%

[3] AMB is a "reverse" measure – lower numbers are better than higher numbers

[4] Tobacco – Level: High = 2015 average + (~10% of RIE); Medium = 2015 average – (~5% of RIE)

[5] Dental – Adults – Level: High = 2015 average + (~4% of RIE); Medium = 2015 average – (~4% of RIE)

SSI MY2017 P4P Targets													
MY2017 P4P Measures	**2015 WI Avg**	**NCQA percentiles (CY2015, aka HEDIS 2016)**						**Level Target**			**RIE Target**		
		25th	*33rd*	*50th*	*67th*	*75th*	*90th*	*High*	*Med*	*Low*	*High*	*Med*	*Low*
AMB - ED Visits (sans revenue code 0456)[6]	**121.28 visits**	N/A	N/A	N/A	N/A	N/A	N/A	<= 115	115.1 - 127	>=127.1	>= 5%	2% - 4.9%	<=1.9%
AMM (continuation) - Depression Rx	**49.5%**	32.8	34.7	38.1	41.5	**43.4**	54.3	>=43.4% (75th p'tile)	38.1% – 43.3%	<=38%	>=5%	2%-4.9%	<=1.9%
Breast Cancer Screen (BCS)	**61.7%**	52.2	53.7	58.1	63.1	**65.3**	71.5	>=65.3% (75th p'tile)	58.1% - 65.2%	<=58.0%	>=10%	5%-9.9%	<=4.9%
CDC-HbA1c Test (Diabetes)	**89%**	83.0	84.1	86.0	88.1	**89.4**	92.9	>=89.4% (75th p'tile)	86.0% - 89.3%	<=85.9%	>=10%	5%-9.9%	<=4.9%
FUH-30 - Follow-up after MH inpatient discharge	**64.7%**	54.6	58.2	**63.9**	**70.4**	72.6	78.5	>=67% (between 67th & 50th p'tile)	63.9% - 66.9%	<=63.8%	>=10%	5%-9.9%	<=4.9%
IET Engagement - AODA	**9%**	6.9	8.0	9.6	11.9	**13.2**	16.9	>=13.2% (75th p'tile)	9.6% - 13.1%	<=9.5%	>=5%	2%-4.9%	<=1.9%
Tobacco (Counseling)[7]	**68.2%**	N/A		N/A	N/A	N/A	N/A	>= 71.5%	66.6% - 71.4%	<=66.5%	>=10%	5%-9.9%	<=4.9%

Note:

P4R HEDIS measures (no targets for MY2017) for both, BC+ and SSI:

1. HbA1c Control (<8.0%)
2. Controlling BP (CBP)

[6] AMB is a "reverse" measure – lower numbers are better than higher numbers. Level: High = ~0.95*MY2015 average; Medium = ~1.05*MY2015 average

[7] Tobacco – Level: High = 2015 average + (~10% of RIE); Medium = 2015 average – (~5% of RIE)

C. Non-HEDIS measure specifications

Annual Dental Visit – Children (BC+ Regions 5 and 6 Only)

- **Measure description:** The % of members 2-20 years of age who had at least one dental visit during the measurement year.
- **Specifications:** The DHS will use the 2018 HEDIS specifications for calculating the results for Annual Dental Visits (ADV). Dental services can be provided by a dental practitioner or a physician. For this measure, a dental practitioner is defined as follows:
  - Per HEDIS, only services rendered by a practitioner who holds a **Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD)** degree from an accredited school of dentistry and is licensed to practice dentistry by a state board of dental examiners.
  - Per HEDIS, **certified and licensed dental hygienists** are considered dental practitioners.
  - Per DHS definitions, dental services (included in the codes above) provided by a **physician** would also count.

Annual Dental Visit – Adults (BC+ Regions 5 and 6 Only)

- **Measure description:** The % of members 21-64 years of age who had at least one dental visit during the measurement year. This is a non-HEDIS measure, developed by DHS.
- **Denominator:**
  - Age: from 21 to 64 years of age.
  - Continuous Enrollment: The member needs to be enrolled in the same HMO continuously for 11 months of the measurement year.
  - Anchor Date: the member needs to be enrolled in the HMO as of Dec. 31 of the measurement year.
- **Numerator:** One or more dental visits with a dental practitioner (see definition above) or a physician during the measurement year. A member had a dental visit if a claim or encounter submitted contains any code listed below:
  - CPT Codes: 70300, 70310, 70320, 70350, 70355, 99188.
  - CDT Codes: D0120-D0999; D1110-D1999; D2140-D2999; D3110-D3999; D4210-D4999; D5110-D5899; D6010-D61999; D6205-D6999; D7111-D7999; D8010-D8999; D9110-D9975, D9999.
  - CDT Codes Excluded: D0145, D1353, D5900-D5999, D9985-D9987, D9991-D9994.
  - CDT Codes removed from the 2017 Dental Procedure Code Set will not be included in the numerator.

Emergency Room Utilization

- **Measure description:** Number of Emergency Department visits per 1000 member months; this is a utilization measure.
- **Specifications**: The DHS will use the 2018 HEDIS specifications and value sets for the results for Ambulatory Care – ED Visits (AMB), excluding revenue code 0456 (Urgent Care).
- **Denominator:** Number of member months during measurement year.
- **Numerator:** Number of Emergency Department visits during the measurement year that do not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.
  - Codes to identify Emergency Department Visits
    - An ED Visit in the HEDIS ED Value Set **excluding** revenue code 456.
    - A procedure code in the HEDIS ED Procedure Code Value Set with an ED place of service code in HEDIS ED POS Value Set.
- **Exclusions:**
  - ED Visits that result in Inpatient Stays
    - ED visits that result in an inpatient stay as defined in the HEDIS Inpatient Stay Value Set are excluded.
  - Behavioral Health
    - The measure does not include mental health or chemical dependency services. The exclusions defined in the HEDIS 2018 Volume 2 Value Set Directory will apply, and include the following:
      - Electroconvulsive Therapy Value Set
      - Mental and Behavioral Disorders Value Set
      - AOD Rehab and Detox Value Set
      - Psychiatry Value Set

Tobacco Cessation – Counseling

- **Measure Description:** Members diagnosed as tobacco users that received tobacco cessation counseling during the measurement year. This is a non-HEDIS measure developed by DHS.
- **Denominator:** The eligible population:
  - Age: Members 12 years of age or older during the measurement year for BC+ members. Members 19 years of age or older during the measurement year for SSI Managed Care members.
  - Continuous Enrollment: The measurement year.
  - Allowable Gap: No More than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
  - Anchor Date: December 31 of the measurement year.
  - Benefits: Medical during the measurement year.
  - Event/Diagnosis: Members are part of the eligible population if they are identified as tobacco users by having at least one encounter or claim in the measurement year with the following codes:

- ICD-10-CM F17200, F17201, F17203, F17208, F17209, F17210, F17211, F17213, F17218, F17219, F17220, F17221, F17223, F17228, F17229, F17290, F17291, F17293, F17298, F17299, Z720.
- All CPT codes are included even from professional, inpatient, or outpatient claims.

- **Exclusions:** Members who have a diagnosis of history of tobacco use, pregnancy, or tobacco use disorder complicating pregnancy during the measurement year:
  - History of Tobacco Use: ICD-10-CM code Z87891.
  - Pregnancy Diagnosis: ICD-10 CM codes O0000 – O9A53.
  - Tobacco Use Disorder Complicating Pregnancyand ICD-10-CM codes O99330, O99331, O99332, O99333.
- **Numerator:** The member is numerator compliant if he or she received counseling to quit smoking either face-to-face or by phone as identified by any claim or encounter with at least one of the codes listed in Table TBC-A during the measurement year and with the following codes in the same encounter:
  - ICD-10-CM F17200, F17201, F17203, F17208, F17209, F17210, F17211, F17213, F17218, F17219, F17220, F17221, F17223, F17228, F17229, F17290, F17291, F17293, F17298, F17299, Z720.

Table TBC-A: Codes to Identify Tobacco Cessation Counseling

CPT	HCPCS		ICD-10-CM
96150-96154, 99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397, 99401 -99404, 99406, 99407, 90832-90834, 90836-90838, 90845, 90847, 90849, 90853, 90875, 90876, 90880, 90899, 98967-98968, 99442-99443.	G9016 S9453		F17200, F17201, F17203, F17208, F17209, F17210, F17211, F17213, F17218, F17219, F17220, F17221, F17223, F17228, F17229, F17290, F17291, F17293, F17298, F17299, Z720.

Please also see the section re: medical record encounter data submission.

D. Performance Measurement and Earn-back Methodology

Performance for **Level** targets will be measured by comparing MY2017 results of an HMO with MY2015 national Medicaid HEDIS percentiles for HMOs as reported in NCQA's Quality Compass; these targets are set in advance and included in this Guide. When Medicaid HEDIS results are not available, the appropriate State-wide or Region-wide averages will be used. BC+ and SSI could have different level targets for the same measures due to the differences in the two populations.

Performance for **RIE** targets will be measured by comparing MY2017 results with baseline MY2015 results of an HMO using the percentage "reduction in error" approach.

- When previous years' data are not available to calculate the "improvement" baseline for an HMO, state-wide averages will be used as that HMO's baseline.
- DHS will specify and/or provide baseline data to HMOs for MY2017, as appropriate.
- HMOs that are new to Medicaid will not have their withhold at risk in their first full or partial year of P4P participation. Their withhold will be returned at the time other P4P payments are made for a particular measurement year. Such HMOs will be subject to full P4P requirements in their second year of participation.

Each HMO's **earn-back** for each measure will be based on a combination of its performance for the Level (high/medium/low), and RIE (high/medium/low), as discussed below:

	Degree of **IMPROVEMENT (RIE)**		
Performance **LEVEL**	**High**	**Medium**	**Low**
High	**100%** earn back		
Medium		**75%** earn back	**50%** earn back
Low		**50%** earn back	**No** earn back*

- As shown in the table, an HMO with "high" performance **Level** will get 100% of its withhold back, regardless of RIE achieved. Also, an HMO with a "high" **RIE** will get 100% of its withhold back, regardless of Level of performance.
- An HMO with insufficient observations (i.e., less than 30 observations in the denominator) for a measure will receive back the amount withheld for that measure.

* **1% Adjustment to "No Earn Back":** For MY2017 and beyond, if an HMO receives a **LOW** rating for a measure for both, Level and RIE, AND it misses its Medium target for Level by less than 1% point, the HMO will be eligible to earn back 50% of its withhold for that measure. For the ED Utilization measure (AMB, which is not a rate but the # of ED visits per 1000 member months), the adjustment will be 0.5 ED visit per 1,000 member months for BC+, and 1 ED visit

per 1,000 member months for SSI. These adjustments are close to 1% of the state average for each population.
The 1% adjustment does not apply to RIE targets. The adjustment will not be available to an HMO if its performance for that measure declines from the previous year.

Reduction in Error (RIE) Example:

The degree of improvement achieved by an HMO is defined as the percentage "Reduction In Error" (RIE) for a given measure in MY2017, compared to its baselines for that HMO.

Consider the following **example**:

1. Assume an HMO's score for a measure for MY2015 was 80%. This forms the RIE baseline, and its MY2015 "error" = 100% - 80% = 20 percentage points.
2. If an HMO attains a score of 82% in MY2017, then it would have achieved a 10% RIE, calculated as:
   - Percentage point increase from last year = 82% - 80% = 2 percentage points
   - This 2% represents one-tenth (or 10%) of the error in MY2015, which was calculated to be 20 percentage points, above.
3. Looking at it from a different point, if an HMO attained a score of 80% in MY2015, it can demonstrate a 10% RIE in MY2017 by attaining a score of 82% in MY2017, because:
   - MY2015 "error" = 100% = 80% = 20 percentage points.
   - 10% reduction in this error = (10% * 20%) = 2 percentage points.
   - 80% + 2% = 82%.
4. If the MY2017 score = 81%, then that HMO will have improved its score by 1 percentage point, which is equal to a 5% reduction in error.

Mathematically, the % RIE for MY2017 = {(MY2017 – MY2015) / Error} * 100,
where Error = (100 – MY2015).

Current Methodology Example – Level and RIE:

The steps below demonstrate how Level and RIE ratings would be calculated under the current methodology.

(a) Set the **MY2017 performance targets** for Level and RIE. Assume MY2015 National Medicaid Quality Compass[8] data for a given measure are:

90th percentile score = 96%
75th percentile score = 92%
50th percentile score = 88%

Then, the MY2017 Level targets are:

- High Level target = 75th percentile score = 92%;
- Medium Level target between the 50th and 75th percentiles = 88% to 91.9%; and,
- Low Level cut-off is below 50th percentile = 87.9% or lower.

[8] Quality Compass data for MY2015 refers to data reported by NCQA for Calendar Year 2015. NCQA released this data in 2016, and labeled it HEDIS 2016.

Also assume that the MY2017 RIE targets are:

- High target = 10% or more RIE
- Medium target = Between 5% and 9.9% RIE; and,
- Low RIE cut-off is 4.8% or lower RIE.

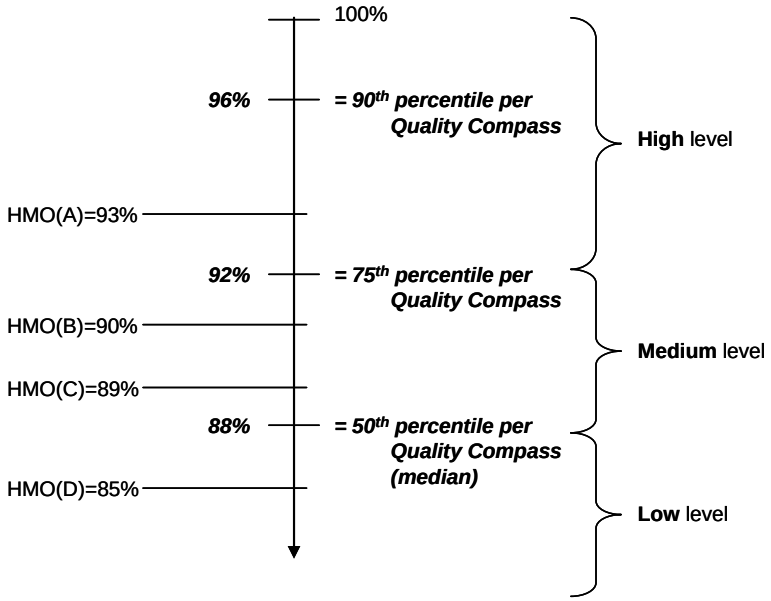
(b) When MY2017 performance data are available, first determine the **Level ratings** for each HMO for each measure, as shown in the following example.

Assume that scores of four HMOs are:

HMO	MY2017 Score
A	93%
B	90%
C	89%
D	85%

Then, compared to the Quality Compass, each HMO's level of performance is rated as follows:

HMO	MY2017 Score	Level rating	Rationale
A	93%	High	Higher than 75th percentile score
B	90%	Medium	Between 50th and 75th percentile
C	89%	Medium	Between 50th and 75th percentile
D	85%	Low	Below 50th percentile



(c) Calculate the **% RIE** for each HMO for that measure (based on MY2015 scores).

HMO	MY2017 Score	MY2015 Score	MY2017 – MY2015	MY2015 Error	RIE rating	
A	93%	93%	0% points	7% points	= (0/7)*100 = 0%	Low
B	90%	89%	1% points	11% points	= (1/11)*100 = 9.1%	Medium
C	89%	89%	0% points	11% points	= (0/11)*100 = 0%	Low
D	85%	83%	2% points	17% points	= (2/17)*100 = 11.8%	High

(d) **Earn-back:** An HMO will earn back its withhold for a measure depending on the combination of its Level and RIE performance ratings, as shown in the example below:

HMO	MY2017 Level rating	MY2017 RIE rating	Withhold earned back
A	High	Low	100%
B	Medium	Medium	75%
C	Medium	Low	50%
D	Low	High	100%

Examples for AMB (ED visits) Measure:

The **scenarios** below illustrate how to determine an HMO's performance for AMB (**lower score is better**). AMB is a utilization measure (ED visits / 1000 member months), with no % value. The following examples use ***hypothetical*** data; actual targets are provided earlier in this Guide:

- MY2015 BC+ State average score (base) = 49.3 ED visits/1000 member months.
- MY2017 BC+ **Level** targets are: High: HMO score <= 50.5 ED visits / 1000 member months; Medium: HMO score between 50.6 and 55; Low: HMO score >= 55.1 visits.
- MY2017 BC+ **Reduction in Error (RIE)** are: High: HMO achieves a 5% or higher reduction of its base; Medium: HMO achieves 3% to 4.9% reduction; Low: HMO achieves 2.9% or lesser reduction.

1. Assume an HMO's MY2015 score for AMB (calculated by DXC) is 55 (= base), and the MY2017 score is 50 visits.

RIE	Level	Earnback
(55-50)/55 = 9.1% RIE = HIGH	HIGH	100%

2. Assume an HMO's MY2015 score is 56 (= base), and the MY2017 score is 53.

RIE	Level	Earnback
(56-53)/56 = 5.4% = HIGH	MEDIUM	100%

3. Assume an HMO's MY2015 score is 53 (= base), and the MY2017 score is 51.

RIE	Level	Earnback
(53-51)/53 = 3.8% = MEDIUM	MEDIUM	75%

4. Assume an HMO's MY2015 score is 54 (= base), and the MY2017 score is 53.

RIE	Level	Earnback
(54-53)/54 = 1.9% = LOW	MEDIUM	50%

5. Assume an HMO's MY2015 score for AMB (calculated by DXC) is 58 (= base), and the MY2017 score is 57.

RIE	Level	Earnback
(58-57)/58 = 1.7% = LOW	LOW	0% (zero) *

* Unless the "1% adjustment" applies.

E. Bonus

The DHS would like to reward BC+ and SSI HMOs that demonstrate high quality by meeting **all** their targets and earning back their **full** withhold. An HMO can earn a bonus on top of its withhold if it meets the following requirements:

1. It receives a rating of "high" (either for Level or for RIE) for **every** measure applicable to it in the P4P set, and,
2. It has reported data for **all** the P4R and core reporting measures, and,
3. A minimum # of P4P measures apply to the HMO, as shown in the table below. A measure may not apply to an HMO if that HMO's denominator is too small for that measure, per HEDIS specifications, or smaller than 30 for non-HEDIS measures.

MY2017: Minimum # of applicable P4P measures for bonus eligibility	
BC+ (non-dental)	6 out of 10 P4P measures
BC+ (dental only)	2 out of 2 P4P measures
SSI	4 out of 7 P4P measures

The total bonus earned by any plan will be the **lesser** of: **2.5%** of the total capitation $ for that plan, OR **Total** withheld $ **forfeited** by other plans.

A bonus pool will be formed by the portion of withhold not earned back (i.e., forfeited) by HMOs. The forfeited withhold will be the sole source of funding for the bonus pool. Eligible HMOs will share the bonus pool in proportion of the sum of the number of members in the **denominator** for all applicable measure, subject to the bonus limits. Rationale**:**

- Variation in the # of members enrolled, i.e., the difference between large and small HMOs, is accounted for by the limit on bonus.
- Variations in the performance of HMOs are accounted for by the high / medium / low ratings for Level and Reduction in error.
- Variation in performance of HMOs due to proportion of enrolled members with specific conditions is accounted for by the use of denominator (not the total enrollment) in calculating the bonus.

Example of bonus calculations

Assume the total bonus pool is worth $2 million for the Measurement Year, and the following plans have met all the bonus eligibility requirements:

HMO	**Total # of members in denominator for all applicable measures**	**% share based on denominator size**	**Bonus amount** (assuming all are below the limits)
A	500	= (500 / 4000) = 12.5%	= 12.5% of $2 million = $250,000
D	400	= (400 / 4000) = 10%	= 10% of $2 million = $200,000
F	2000	= (2000 / 4000) = 50%	= 50% of $2 million = $1 million
H	1100	= (1100 / 4000) = 27.5%	= 27.5% of $2 million = $550,000
Total	**4000**	**100%**	**$2 million**

F. Data Submission and Reporting for BC+ and SSI

1. Submitting / calculating results

The following table shows who will calculate / submit results for each measure for MY2017:

P4P Measure	BC+	SSI
Antidepressant Medication Management- Continuation	HMO	HMO
Breast Cancer Screening	HMO	HMO
Comprehensive Diabetes Care – HbA1c Testing	HMO	HMO
Comprehensive Diabetes Care – HbA1c Control < 8% (NQF 0575); (P4R – pay for reporting only for MY2017)	HMO	HMO
Controlling Blood Pressure < 140/90 mmHg (NQF 0018); (P4R – pay for reporting only for MY2017)	HMO	HMO
Childhood Immunizations-Combination 3	HMO	N/A
ED Visits (AMB) *sans revenue code 0456 (Urgent Care)*	DXC	DXC
Follow-Up After Mental Health Hospitalization – 30 Days	HMO	HMO
Initiation and Engagement of AOD Treatment – Engagement	HMO	HMO
Prenatal and Postpartum Care	HMO	N/A
Tobacco Cessation Counseling	DXC	DXC
Dental care for children and adults (Regions 5, 6 only)	DXC	N/A

2. Member Level Detail files

To simplify the administrative tasks associated with P4P, the DHS will not require the HMOs to submit the member level detail files for MY2016. However, at a later date, if the DHS needs to verify the results reported by the HMOs, the DHS reserves the right to request member-level detail from specific HMOs, as appropriate. Therefore, HMOs are encouraged to be ready to provide the member-level details, if needed.

3. Supplemental data

HMOs may submit **additional / supplemental data (member level detail is required)** to augment results for measures calculated by DXC. Supplemental data are in addition to and different from the administrative data and the Medical Record Encounter (explained below). Such data should be submitted via SFTP, and may pertain only to data collected through chart review or other means.
If an HMO desires to submit supplemental data for up to **less than 25 members** across all measures for the MY, it may submit data directly to the DHS staff using SFTP. HMOs are asked to inform the DHS staff separately if they submit any data through SFTP.
If an HMO desires to submit quality data for 25 or more members across all measures for the MY, it should follow the Medical Record Encounter Guidance, discussed below.

4. Medical Record Encounter Guidance (X12 837)

HMOs may submit chart data in addition to administrative data when the administrative data do not fully capture the true performance of an HMO. Medical Record Encounter data have the same submission deadline as administrative encounter data as pertaining to quality measures. Due to logistical reasons, Medical Record Encounters submitted after the deadline for administrative data cannot be included in calculation of quality performance.

This section provides guidance to the HMO staff for submitting chart reviewed data for the quality measures, e.g., when creating an encounter from medical record information. The review guidelines should first be discussed with the HMO technical staff, which can assist them with submitting the information in the required format. All HMOs are expected to follow the X12 837 standards when submitting encounters. This supplemental data may pertain only to that collected through chart review or other means, and not encounter data.

Background

a. An encounter record may be created from data acquired through medical record or chart review, or other non-claim sources.

b. This is done when the HMO wishes to supplement its encounter data set, **but no claim was received for the service provided. Examples include: HealthCheck services, medical records transferred from another state.**

c. The only medical record/chart reviewed data that may be submitted is information obtained from a provider or clinician, **and must meet the following criteria:**

   i. The date of service should be within the specifications of the measures for the MY.

   ii. When a test result is needed, the medical record includes a note indicating the date of service and the result.

   iii. Electronic supplemental data may be used if the information is related to the disease being managed, the reported value was measured by a health care provider, and the information is either in the member's medical record or the HMO has the ability to access the information (example: WIR).

d. Member reported biometric values from self-administered tests are not acceptable.

e. Member survey information may not be used.

f. If the review supplements an existing encounter record, do not submit the additional data as a medical record reviewed encounter. Adjust or void and resubmit the original encounter.

g. DMS Required Fields for Medical Record/Chart Review Data (Please work with your technical staff to get the appropriate information from the companion guide).

Required 837 Detail Fields for Medical Record/Chart Review

a. All HMOs are expected to follow the X12 837 standards when submitting encounter data, even when it comes in by chart review. Included in the 837 standards are

instructions for identifying the encounter as a chart review. The list below identifies the fields that are specific to chart reviewed data. Keep in mind that your data submissions should begin with the 837 standards. Please work with your technical staff to utilize the appropriate information from the companion guide.

b. Loop 2330 NM 109 – Other Payer Primary Identifier (This is the HMO ForwardHealth ID)

c. Inner Envelope BHT06 – Encounter ID. Use Loop 2300 with PWK01 = 09. Any encounter submitted with 09 in the PWK01 segment will be labeled as a chart review. (Data source 1, 2, 3 is no longer used). These services will not be used for encounter rate setting.

d. Loop 2300 with PWK – Use this segment when it is necessary to indicate an encounter chart review.

e. Loop 2300 PWK 01 – Report Type Code = 09 (Encounter). Added element. Element will designate a chart review encounter.

f. Loop 2300 PWK02 – Attachment Transmission Code AA. This means that the attachment is available by request at provider site.

Chart Review FAQ's

- Will the Department accept the clinic as the rendering provider?
  - Data pulled from the medical record must comply with the guidelines concerning HEDIS data element requirements and audit review. Supplemental data may be used if the information is related to the disease being managed, the reported value was measured by a health care provider and the information is either in the member's medical record or the HMO has the ability to access the information. If the rendering provider number is not available, the HMO may use their HMO ID number.
- Will the department accept reviewed medical records with the clinic NPI when the rendering NPI is not available? Also, can the department populate the diagnosis or procedure code fields?
  - The department will accept reviewed records with the HMO ID number when the rendering NPI is not available. The data will not be used to calculate HMO rates.
  - The department will not accept medical record reviewed data without the diagnosis or procedure codes. This is consistent with HEDIS requirements.

5. Fee-For-Service (FFS) data for BC+ All Regions

By December 2017, the DHS plans to provide data to HMOs for members who received care under FFS during the MY, when they were not enrolled in an HMO, so that HMOs can get the credit for care provided while the members were enrolled in FFS. In prior years, HMOs have preferred to receive this data by December, so these FFS files will not reflect the full MY2017 data due to the associated time lags.

6. NCQA Data submission requirements - BC+ and SSI - All Regions

HMOs are required to submit the following for MY2017:

a. Data from the NCQA Interactive Data Submission System (IDSS) site containing the required data elements and the denominator and numerators for each measure in the Data-filled Workbook (export), filled copy of this workbook in Excel format for local copy and for printing. HMOs must provide to the DHS the **denominators and numerators for each measure**.
b. **Data Filled Workbook, including Audit Review Table (ART) format** downloaded from the NCQA IDSS site (with evidence that the auditor lock has been applied).
c. The Audit Report produced by a NCQA Licensed HEDIS Auditor.
d. For measures with age stratification, HMOs are asked to report results in the IDSS and ART tables by age strata as well as for the overall population.

7. Electronic submission requirements:

a. Data files and documents are to be submitted to DHS via the SFTP server.
b. All electronic data files must include the year and health plan name in the file name.
c. Send an email to Mitzi.Melendez@wi.gov and to VEDSHMOSupport@wisconsin.gov notifying them when the files (test files or production files) have been placed on the SFTP server with the number of records in each file.

8. Public Reporting

For MY2017, all health plans are asked to report each of their HEDIS scores verified by their HEDIS auditor for all regions, and to make their results available for public reporting within the Quality Compass. As in the past, the DHS (DXC) will calculate the applicable HEDIS-like or non-HEDIS scores (e.g., for tobacco cessation, AMB-ED Visits, Dental measures for children and adults).

9. Other P4P requirements:

a. Rotation of measures is not allowed. Each measure is to be calculated each year.
b. Health plans may apply the optional exclusions per HEDIS specifications for appropriate measures while submitting audited Medicaid HEDIS results to NCQA.
c. In determining continuous enrollment for specific measures, HEDIS allows a gap of 45 days for commercial plans, but only a one-month gap for Medicaid plans that enroll on a monthly basis. Wisconsin Medicaid enrolls members on a monthly basis. The only time a member is not enrolled for the entire month is the month in which a child was born. Refer to the General Guidelines in the HEDIS Technical Specifications.
d. For HEDIS measures that can be collected using the hybrid method, inclusion of chart review data is optional.
e. HMOs may use the sample approach to calculate their results when permitted by HEDIS.
f. HMOs are asked to submit their final version of the encounter data and Medical Encounter Record data for the Measurement Year by the date specified in the Timeline section of this document. These data will be used by the DHS and DXC, its analytics vendor to calculate the results for HEDIS-like measures. Once the

encounter data have been extracted by DXC for P4P results, further changes to that data will not be feasible.

G. Participating HMOs

The table below lists the 18 BC+ HMOs and 10 SSI HMOs participating in the P4P and Core Reporting initiatives for MY2017. This list is updated annually.

HMO	BC+	SSI
1. Care Wisconsin Health Plan		✓
2. Children's Community Health Plan	✓	
3. Anthem	✓	✓
4. CompCare	✓	✓
5. Dean Health Plan	✓	
6. Group Health Cooperative of Eau Claire	✓	✓
7. Group Health Cooperative of South Central WI	✓	
8. Gundersen Health Plan	✓	
9. Health Tradition Health Plan	✓	
10. Independent Care Health Plan (iCare)	✓	✓
11. MercyCare Insurance Company	✓	
12. Managed Health Services	✓	✓
13. Molina Health Care WI	✓	✓
14. Network Health Plan	✓	✓
15. Physicians Plus Insurance Corporation	✓	
16. Security Health Plan of WI	✓	
17. Trilogy Health Insurance	✓	✓
18. UnitedHealthcare of Wisconsin	✓	✓
19. Unity Health Plans Insurance Corporation	✓	

H. Modifications due to ICD-10

ICD-10 has the potential to influence the results for P4P measures, because the MY2017 results will be based on ICD-10, while the baselines and targets will be set using a combination of ICD-9 and ICD-10 based MY2015 results. The table below shows which P4P measures are susceptible to ICD-10 implementation (based on advice from the DHS' HEDIS expert from MetaStar, the EQRO).

MY2017 measures potentially impacted by ICD-10	MY2017 measures not impacted by ICD-10
• AMB (ED visits) • HbA1c testing (diabetes) • FUH-30 (follow-up after discharge for mental health inpatient care) • IET – engagement (substance abuse) • PPC (2 measures - prenatal & postpartum care) • Tobacco cessation counseling	• AMM (antidepressant medication management) • BCS (breast cancer screening) • CIS (childhood immunization) • ADV (2 measures - dental care for children & adults)

After multiple discussions, the DHS and HMOs agreed to apply some after-the-fact adjustments to MY2016 and MY2017, in order to account for the potential impact of change from ICD-9 to ICD-10. The DHS shared a detailed presentation with the HMO Contract Administrators on February 25, 2016 (provided in the MY2016 Guide, but not repeated in this Guide).

Although the steps below mention MY and CY 2014 and 2016, the DHS will apply a similarly informed adjustment approach to MY2017 when MY2017 results are available.

Step 1: Use the data from CY2014 HEDIS percentiles to set the Level targets (High, Medium and Low) for Calendar Year (CY) 2016. This follows the current P4P methodology.

Step 2: When CY2016 HEDIS percentiles are published by NCQA in Fall 2017, compare the value of the CY2016 High Level target percentile (e.g., 75th) to the value of the next lower (e.g., 67th) percentile from CY2014. This comparison will help determine if the percentile curve has shifted between CY2014 and CY2016.

Decision Rule:

IF the value of the CY2016 **High** Level target percentile (e.g., 75th) is **at or below** the CY2014 value of the next lower percentile (e.g., 67th), it suggests a significant shift in the percentile curve between CY2014 and CY2016, and CY2016 targets should be **revised**. Otherwise, continue to use the targets based on CY2014 HEDIS percentiles.

Revised Target:

If there is a significant shift in the percentile curve, replace the original (CY2014) value of the Level target (e.g., 75th percentile) with CY2016 value of the same target percentile (e.g., 75th). In other words, the target percentile does not change due to a significant shift, but the target value changes from that in CY2014 to the one from CY2016.

Additional notes:

1. The above methodology protects HMOs from any significant downward shift of the percentile curves. Upward shifts in the percentile curves will not lead to revision of targets.
2. The High / Medium / Low performance grid will apply to Level and RIE targets in all situations.
3. Comparisons between CY2014 and CY2016 percentiles will focus only on the value of the High Level target, because the other targets and cut-off points cascade from it.
4. RIE baseline and targets remain unchanged (CY2014 data).
5. The 1% adjustment will continue, though the 10-member adjustment has been eliminated for MY2016 and beyond.

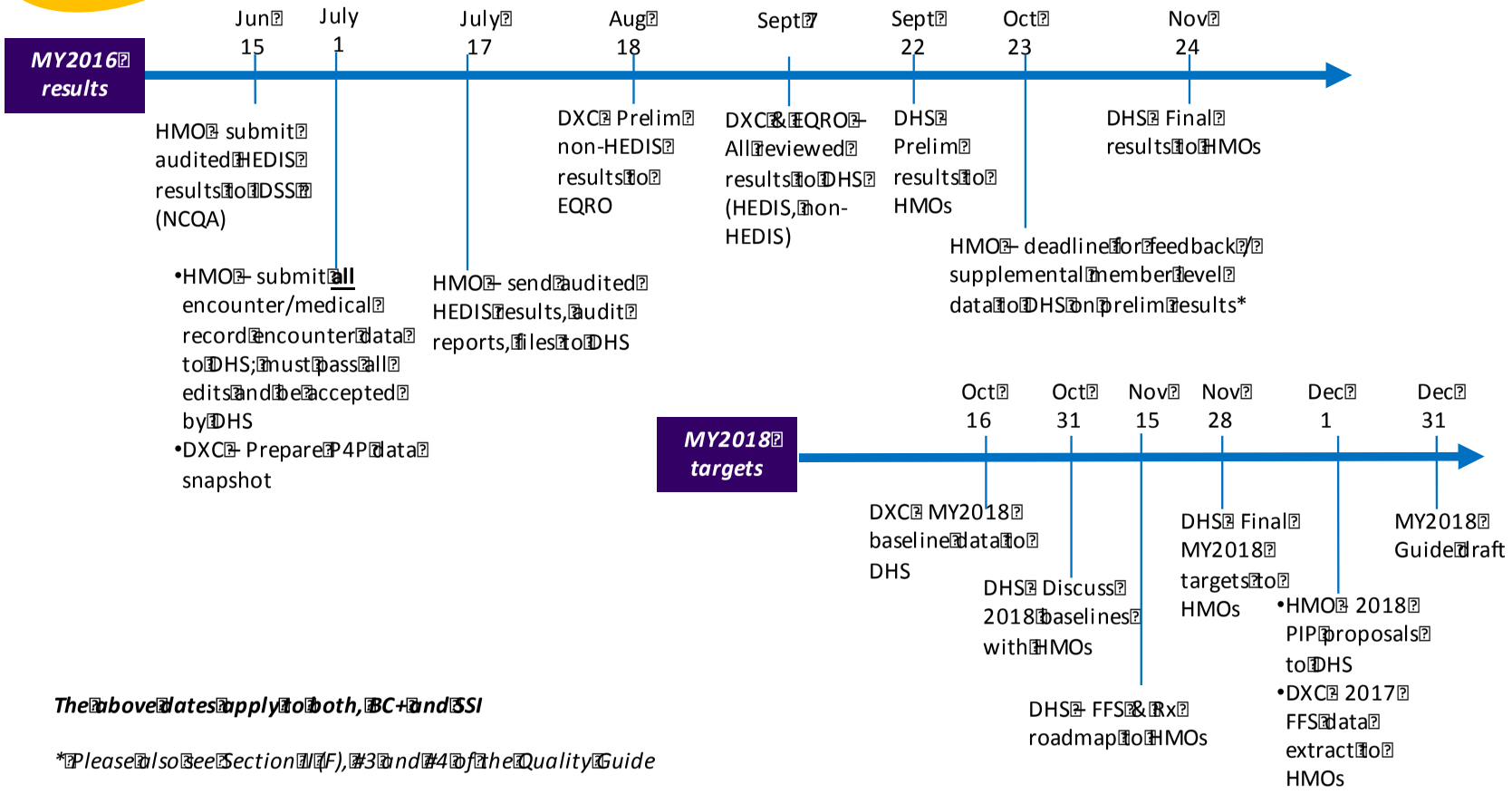
I. Timeline for Calendar Year 2017

Timely completion of the P4P initiative requires close coordination between multiple entities (the DHS, DHS' analytics vendor, HMOs, HEDIS auditors of HMOs, NCQA, etc.), as shown below:

HMO P4P Timeline during CY2017

for MY2016 results and MY2018 targets

Updated 5-18-2017



The above dates apply to both, BC+ and SSI

**Please also see Section VI(F), #3 and #4 of the Quality Guide*

III. Core Reporting (CR)

As part of its initiatives to improve alignment with current and future CMS requirements (e.g., CHIPRA, Managed Care Rules) and as input to a broader picture of Quality of Care, the DHS would like all plans to report audited HEDIS data for the additional measures for MY2017 shown in the table below. Many HMOs already report data on the following measures through their annual HEDIS submission to the DHS. The Core Reporting measures are not part of P4P withhold or bonus for MY2017.
HMOs will be subject to a $10,000 penalty per measure for not reporting HEDIS data for the measures listed below.

Core Reporting Measure		
	BC+	**SSI**
Preventive / screening	Adult BMI (ABA) Adult access to preventive care (AAP) Adolescent immunization (IMA) Children/adolescent access to preventive care (CAP) Well-child visits in first 15 months (W15) Well-child visits in the Third, Fourth, Fifth and Sixth years (W34) Adolescent well care visits (AWC)	Adult BMI (ABA) Adult access to preventive care (AAP)
Pregnancy / birth	Frequency of ongoing prenatal care (FPC)	N/A
Mental health / substance abuse	Mental health utilization (MPT)	Mental health utilization (MPT)
Blood lead testing (LSC)	Target = 75th percentile for MY2015 NCQA Quality Compass (not P4P for MY2017)[9]	N/A

Blood Lead Testing (HEDIS LSC): The MY2017 target for LSC is set at the MY2015 national 75th percentile, at **79.5%**. A flat penalty of $10,000 (not part of P4P) will be applied to HMOs not meeting the MY2017 target. The DHS will continue to monitor the MY2016 results, to be available in 2017.

HEDIS Depression Measures using ECDC: In addition, the DHS would like all HMOs serving BC+ and / or SSI populations to start preparing to report HEDIS data on the following two relatively new HEDIS depression measures:

- Monitor depression symptoms using PHQ-9 (DMS) – chart data / ECDS – since 2016
- Depression remission using PHQ-9 (DRR) - chart data / ECDS – new for 2017

[9] The DHS held a detailed discussion on this topic with HMOs in the October 2016 Quality Conference Call.

The DHS recognizes that HMOs might not be ready to implement these measures in MY2017, and DHS asks each HMO to submit a plan (by August 15, 2017), with specific actions and timeline, that will bring the HMO to the level of readiness required for reporting data for these measures for MY2018. HMOs will be asked to submit a brief status report for this plan by December 31, 2017.

Plan for MY2018 and MY2019: In compliance with the effective NCQA specifications and requirements at the time of submission, HMOs will be asked to report data using ECDS for these two measures for MY2018 and MY2019, respectively. HMOs will submit data for these two measures as part of their annual HEDIS data submission to DHS. $10,000 Penalty for non-submission of data applies to these two measures. These measures will not be part of P4P or P4R. During MY2019, DHS will evaluate these two measures for inclusion in the MY2020 P4P and/or "core reporting" measures with performance targets.

IV. SSI Care Management (in development)

In addition to the P4P and CR measures, the DHS and its EQRO are developing qualitative and quantitative measures to assess the implementation and effectiveness of the SSI Care Management initiative. These measures and a timeline will be discussed with the HMOs in 2017, and appropriate content will be added to this Guide.

DHS is preparing a draft timeline for SSI Needs Stratification PIPs for 2017, to help HMOs to be ready for the formal PIPs for Needs Stratification by December 2017.

V. Health Needs Assessment Guide

The following HNA Guide was shared by DHS with the HMOs in May 2017.

2017 HNA Guide 5-12-2017.doc

VI. HealthCheck Specifications

DHS plans to include HealthCheck results in the HMO Report Card, and to issue Corrective Action Plans to HMOs not meeting the HealthCheck targets.

Measure Description:

The percentage of the required age-appropriate comprehensive screenings for members under 21 years of age conducted in the measurement year.

To be considered a comprehensive HealthCheck screen, the provider must conduct and document the following assessments:

- A complete health and developmental history (including anticipatory guidance).
- A comprehensive unclothed physical examination.
- An age-appropriate vision screening exam.
- An age-appropriate hearing screening exam.
- An oral assessment plus referral to a dentist beginning at one year of age.
- The appropriate immunizations (according to age and health history).
- The appropriate laboratory tests (including blood lead level testing when appropriate for age).

Codes

Number of comprehensive screenings completed by age group is identified by the following:

- Procedure Codes:

  <u>CPT – 4 Codes: Preventive Medicine Services *</u>

  - 99381 – New patient under one year
  - 99382 – New patient (ages 1 – 4 years)
  - 99383 – New patient (ages 5 – 11 years)
  - 99384 – New patient (ages 12 – 17 years)
  - 99385 – New patient (ages 18 – 39 years)
  - 99391 – Established patient under one year
  - 99392 – Established patient (ages 1 – 4 years)
  - 99393 – Established patient (ages 5 – 11 years)
  - 99394 – Established patient (ages 12 – 17 years)
  - 99395 – Established patient (ages 18 – 39 years)
  - 99460 – Initial hospital or birthing center care for normal newborn infant
  - 99461 – Initial care in other than a hospital or birthing center for normal newborn infant
  - 99463 – Initial hospital or birthing center care of normal newborn infant (admitted/discharged same date)

* These CPT codes do not require use of an ICD-9-CM "V" code or an ICD-10-CM "Z" code.

CPT – 4 codes: Evaluation and Management Codes**

- 99202-99205: New patient
- 99213-99215: Established patient

** These CPT-4 codes must be used in conjunction with:

- ICD-9-CM codes V20-V20.2, V20.3, V20.31 and V20.32 and/or V70.0 and/or V70.3-V70.9 ***OR***
- ICD-10-CM codes:
    - Z76.2 – Encounter for health supervision and care of other healthy infant and child,
    - Z00.121 – Encounter for routine child health examination with abnormal findings,
    - Z00.129 – Encounter for routine child health examination without abnormal findings.
    - Z00.110 – Health examination for newborn under 8 days old and
    - Z00.111 – Health examination for newborn 8 to 28 days old and/or
    - Z00.00-01 – Encounter for general adult medical examination without/with abnormal findings and/or
    - Z02.0 – Encounter for examination for admission to educational institution,
    - Z02.1 – Encounter or pre-employment examination,
    - Z02.2 – Encounter for examination for admission to residential institution,
    - Z02.3 – Encounter for examination for recruitment to armed forces,
    - Z02.4 – Encounter for examination for driving license,
    - Z02.5 – Encounter for examination for participation in sport,
    - Z02.6 – Encounter for insurance purposes,
    - Z02.81 – Encounter for paternity testing,
    - Z02.82 – Encounter for adoption services,
    - Z02.83 – Encounter for blood-alcohol and blood-drug test,
    - Z02.89 – Encounter for other administrative examinations,
    - Z00.8 – Encounter for other general examination,
    - Z00.6 – Encounter for examination for normal comparison and control in clinical research program,
    - Z00.5 – Encounter for examination of potential donor of organ and tissue,
    - Z00.70 – Encounter for examination for period of delayed growth in childhood without abnormal findings,
    - Z00.71 - Encounter for examination for period of delayed growth in childhood with abnormal findings.

Work Sheet:
DHS will use the HealthCheck worksheet below to measure compliance with the 80% target of HealthCheck comprehensive visits in the 2017 BadgerCare Plus and Medicaid SSI HMO Contract.

An HMO that does not meet the target will be subject to one penalty, combined, for BadgerCare Plus and SSI contracts.

The results for this measure are calculated by DHS using the following HealthCheck Worksheet (also see the example later in this section):

			Age Groups					
		Calculation	**< 1**	**1 – 2**	**3 – 5**	**6 – 14**	**15 – 20**	**Total**
1	# of eligible months for members under age 21	Entered (Total is sum across all age groups)						
2	# of unduplicated members under age 21	Entered						
3	# of recommended screens per age group	Per CMS / State specifications	5	1.5	1	0.5	0.5	
4	Average period of eligibility in years	=Line 1 ÷ Line 2 ÷ 12						
5	Adjusted # of recommended screens per age group	=Line 3 x Line 4						
6	Expected # of screens (100% of required screens for ages and months of eligibility)	=Line 2 x Line 5 (Total is sum of age groups)						
7	# of screens required to meet the 80% goal	=Line 6 x 0.80						
8	Actual # of screens completed	Entered						
9	Did the HMO meet the goal?	=Line 8 – Line 7 (If negative, goal was not met)						
10	Penalty	$10,000 if "Total" for line 9 is negative						

Explanation of the HealthCheck Worksheet

- Row #1: Member months for members in the eligible population, under 21 years of age during the measurement year, broken out by:
  - < 1 year
  - 1 – 2 years
  - 3 – 5 years
  - 6 – 14 years
  - 15 – 20 years
  - Each member will be assigned to an age group based on their age on December 31 of the measurement year.

  Anchor Date for the measure: December 31 of the measurement year.
- Row #2: # of unique, unduplicated members in the eligible population.

- Row #3: Expected # of screens for an individual member in each age group, based on CMS recommendations / specifications.
- Row #4: Average period of eligibility during the Measurement Year (MY), expressed as a proportion of the year (not in months)
  = # of member months / (# of unique members / 12 months)
- Row #5: # of expected screens for an average member in each age group, adjusted for the average period of eligibility in that age group.
- Row #6: # of expected screens for all members in the HMO in each age group, adjusted for the average period of eligibility.
- Row #7: # of screens that the HMO is required to have for each age group in order to meet the 80% goal, after adjustment for the # of unique members and their average eligibility period within each age group.
- Row #8: Actual # of HealthCheck screens completed by the HMO during the MY for each age group.
- Row #9: This is equal to the difference between Row #8 and Row #7 (=Row #8 – Row #7), aggregated across all age groups. A negative value in the "Total" cell indicates the HMO failed to meet the 80% HealthCheck goal during the MY.
- Row #10: If the HMO failed to meet the 80% HealthCheck goal during the MY, a penalty of $10,000 is applied.

HealthCheck Worksheet EXAMPLE:

DHS will use the HealthCheck worksheet below to measure compliance with the 80% target of HealthCheck comprehensive visits in the 2016 BadgerCare Plus and Medicaid SSI HMO Contract.

Assume the numbers in Rows #1, 2 and 3 are given.

			Age Groups					
		Calculation	**< 1**	**1 – 2**	**3 – 5**	**6 – 14**	**15 – 20**	**Total**
1	# of eligible months for members under age 21	Entered (Total is sum across all age groups)	1,200	1,200	1,200	1,200	1,200	6,000
2	# of unduplicated members under age 21	Entered	120	120	120	120	120	600
3	# of recommended screens per age group	Per CMS / State specifications	5	1.5	1	0.5	0.5	
4	Average period of eligibility in years	=Line 1 ÷ Line 2 ÷ 12	0.833	0.833	0.833	0.833	0.833	
5	Adjusted # of recommended	=Line 3 x Line 4	4.167	1.250	0.833	0.417	0.417	

			Age Groups					
		Calculation	**< 1**	**1 – 2**	**3 – 5**	**6 – 14**	**15 – 20**	**Total**
	screens per age group							
6	Expected # of screens (100% of required screens for ages and months of eligibility)	=Line 2 x Line 5 (Total is sum of age groups)	500	150	100	50	50	850
7	# of screens required to meet the 80% goal	=Line 6 x 0.80	400	120	80	40	40	680
8	Actual # of screens completed	Entered	350	98	86	38	43	615
9	Did the HMO meet the goal?	=Line 8 – Line 7 (If negative, goal was not met)						-65
10	Penalty	$10,000 if "Total" for line 9 is negative						$10,000