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

HMO Quality Guide

Measurement Year (MY2023)

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

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For all questions, please email: DHSDMSHMO@dhs.wisconsin.gov ***Please CC your HMO analyst on all emails.***

DMS maintains an email list for monthly Quality Forum meetings as well as general quality updates. To add or remove HMO email addresses from this HMO quality list, please email DHSDMSHMO@dhs.wisconsin.gov.

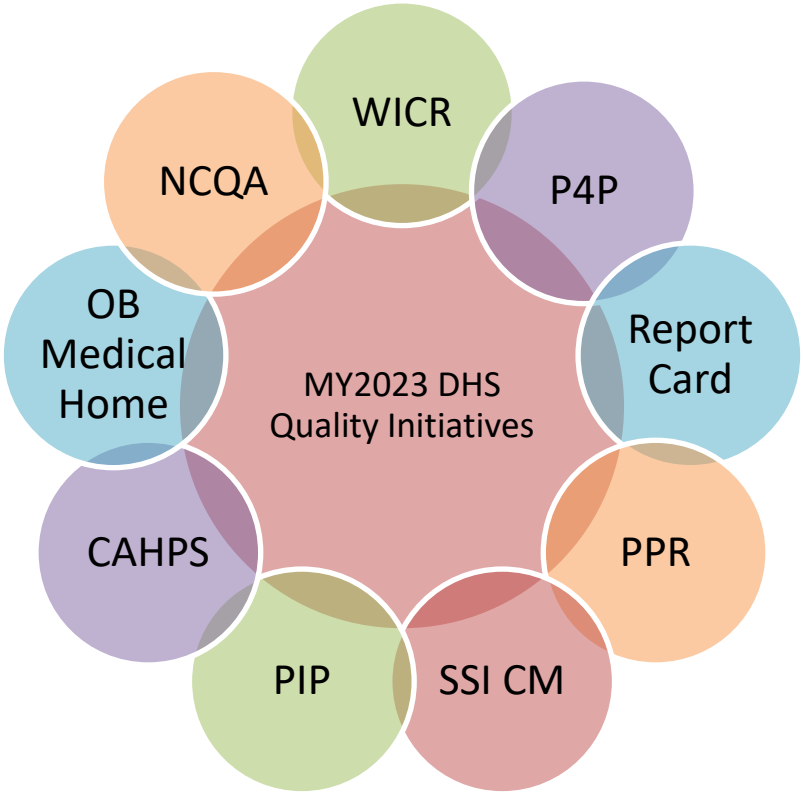
Other information:

See Appendix D - Deliverable Due Dates and Submission

Version	Date	Change Log
1.0	Sept 9, 2022	Initial Version

I. Measurement Year 2023 Overview

The quality initiatives of the Wisconsin Department of Health Services, Division of Medicaid Services (DMS) cover a broad range of initiatives, as shown below:



- The Wisconsin Core Reporting **(WICR)** initiative focuses on providing DMS healthcare quality data for a broad set of conditions and measures related to the Medicaid Core Sets published by CMS. WICR does not include a withhold but requires HMOs to report data on specific quality measures and imposes financial penalties for not reporting results. DMS submits Pay-for-Performance **(P4P)** and WICR results to the Centers for Medicare & Medicaid Services (CMS) and CMS publishes an annual scorecard of state performance.
- The **P4P** initiative focuses on improving the measurable quality of care for Medicaid members served by HMOs. HMOs are subject to capitation withholds that HMOs can earn back based on their performance relative to quality targets for various measures. These measures relate to DMS priorities, while balancing the total number of measures in P4P. DMS continues to move from process-only measures to a combination of process and outcome measures (e.g., from HbA1c Testing to HbA1c Control, related to diabetes care).
- The **HMO Report Card** evaluates the quality of health care that Medicaid members receive from BadgerCare Plus and Medicaid SSI HMOs based on performance data provided by the HMOs. A 5-star rating system is used to compare HMOs on major areas of care using national and state-wide benchmarks.

- The **Potentially Preventable Readmissions (PPR)** initiative focuses on reducing preventable hospital readmissions following an initial admission. Excess readmissions compared to state-wide benchmarks suggest an opportunity to improve patient outcomes and to reduce costs through better discharge planning, better coordination of care across sites of service, and/or other improvements in the delivery of care.
- The **SSI Care Management** initiative aims to provide person-centric care through needs stratification, integration of social determinants, person-centric care plans, interdisciplinary care teams, and on-going assessments and alignment of the SSI members' needs with their care.
- HMOs conduct two **Performance Improvement Projects (PIPs)** each year as part of their quality assessment and performance improvement (QAPI) program. A PIP is a project conducted by the HMO that is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. For MY2023, both PIPs must focus on reducing health disparities among Medicaid members and compliance with the Managed Care Rule requirement defined in 42 CFR 438.340 (b).
- The **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** survey is a survey tool used by DMS to survey both fee-for-service and HMO member experience and satisfaction with care. The survey is performed annually for children in BadgerCare Plus or CHIP populations, and data is shared with CMS.
- **OB Medical Home** is an initiative to improve birth outcomes and reduce birth disparities among high-risk pregnant members enrolled in BadgerCare Plus and Medicaid SSI HMOs by providing enhanced care coordination services.
- **National Committee for Quality Assurance (NCQA) Accreditation** is a nationally recognized review process. DMS recognizes NCQA Health Plan Accreditation to avoid duplication of External Quality Review (EQR) activities. DMS will require all HMOs to be accredited for Medicaid, as well as a distinction or certification regarding culturally appropriate care, by December 31, 2023.

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

These quality initiatives are part of the DMS Medicaid Managed Care Quality Strategy[1], which is a three-year strategic plan to improve quality and ensure quality assurance and compliance within managed care programs, including HMOs.

Depending on the specific Medicaid members served, an HMO might participate in multiple quality initiatives.

[1] DMS Medicaid Managed Care Quality Strategy
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/Home.htm.spage

Participating HMOs

The table below lists the BadgerCare Plus (BC+) HMOs and Supplemental Security Insurance-Related Medicaid (SSI) HMOs participating in the P4P and Core Reporting initiatives for MY2023. This list is updated annually.

	HMO	BC+	SSI
1.	Anthem Blue Cross and Blue Shield	✓	✓
2.	Chorus Community Health Plans	✓	
3.	Dean Health Plan	✓	
4.	Group Health Cooperative of Eau Claire	✓	✓
5.	Group Health Cooperative of South Central Wisconsin	✓	
6.	Independent Care (iCare)	✓	✓
7.	Mercy Care Insurance Company	✓	
8.	MHS Health Wisconsin	✓	✓
9.	Molina Healthcare	✓	✓
10.	My Choice Wisconsin Health Plan Inc	✓	✓
11.	Network Health Plan	✓	✓
12.	Quartz	✓	✓
13.	Security Health Plan of Wisc	✓	✓
14.	United Healthcare Community Plan	✓	✓

II. Wisconsin Core Reporting (WICR)

Note: This section is current as of the release of Version 1.0 of the 2023 Quality Guide; however, it will be updated once CMS publishes the final 2023 Child Core Set and Adult Core Set in December 2022. There may be further revisions to the list of WICR measures based on the final Core Set lists.

The Bipartisan Budget Act of 2018 (P.L. 115-123) requires states to report on the Child Core Set for Medicaid and CHIP beginning with reports for fiscal year (FY) 2024. In addition, section 5001 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) 2018 made state reporting of the Behavioral Health Core Set for adults mandatory starting in FY 2024. While Adult Core Set measures, other than behavioral health, are not mandatory, DMS is working towards improving the number of measures from the Adult Core Set reported to CMS each year.

To improve alignment with current and future CMS requirements (e.g., CHIPRA, Managed Care Rules) and improve quality of care, DMS requires all plans to report audited Healthcare Effectiveness Data and Information Set (HEDIS) data for key measures designated as **Wisconsin Core Reporting (WICR).**

1. 2023 WICR measures are all the NCQA[2] HEDIS measures included in either the 2023 CMS Adult or Child Core Set.
2. HMOs will be subject to a **$10,000 penalty** per measure for not reporting HEDIS data for any WICR measure as applicable to BC+ and SSI, shown in the table in **Appendix E**.
3. General Submission Considerations
    - HMOs should report results using standard HEDIS specifications unless otherwise specified in **Appendix F.**
    - HMOs are asked to report all age bands, sub-populations, and any applicable totals for the measures using standard HEDIS technical specifications.
    - HMOs should follow guidelines for denominators less than 30.
    - If an HMO is unable to generate a WICR measure due to the specifications being tailored to CMS rather than NCQA, the HMO must submit a letter by July 31, 2023, to DMS clearly stating the reason(s) for its inability to generate this measure, along with its regular HEDIS data submission to DMS (e.g., Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD))

For a full list of WICR measures, in addition to P4P measures and non-WICR measures that are to be reported to DMS, see Appendices E and F.

CMS Medicaid 2023 Adult Core Set (link to be updated when CMS releases 2023 Core Set)

CMS Medicaid 2023 Child Core Set (link to be updated when CMS releases 2023 Core Set)

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

III. Pay-for-Performance (P4P)

Note: This P4P section is in placeholder status. P4P Measure selection, baseline data, targets, and withhold rates are all pending measure result analysis and the release of 2022 Quality Compass.

Scope

- **BC+:** Standard plan in all 6 Medicaid Regions
- **SSI:** All 6 Medicaid 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).

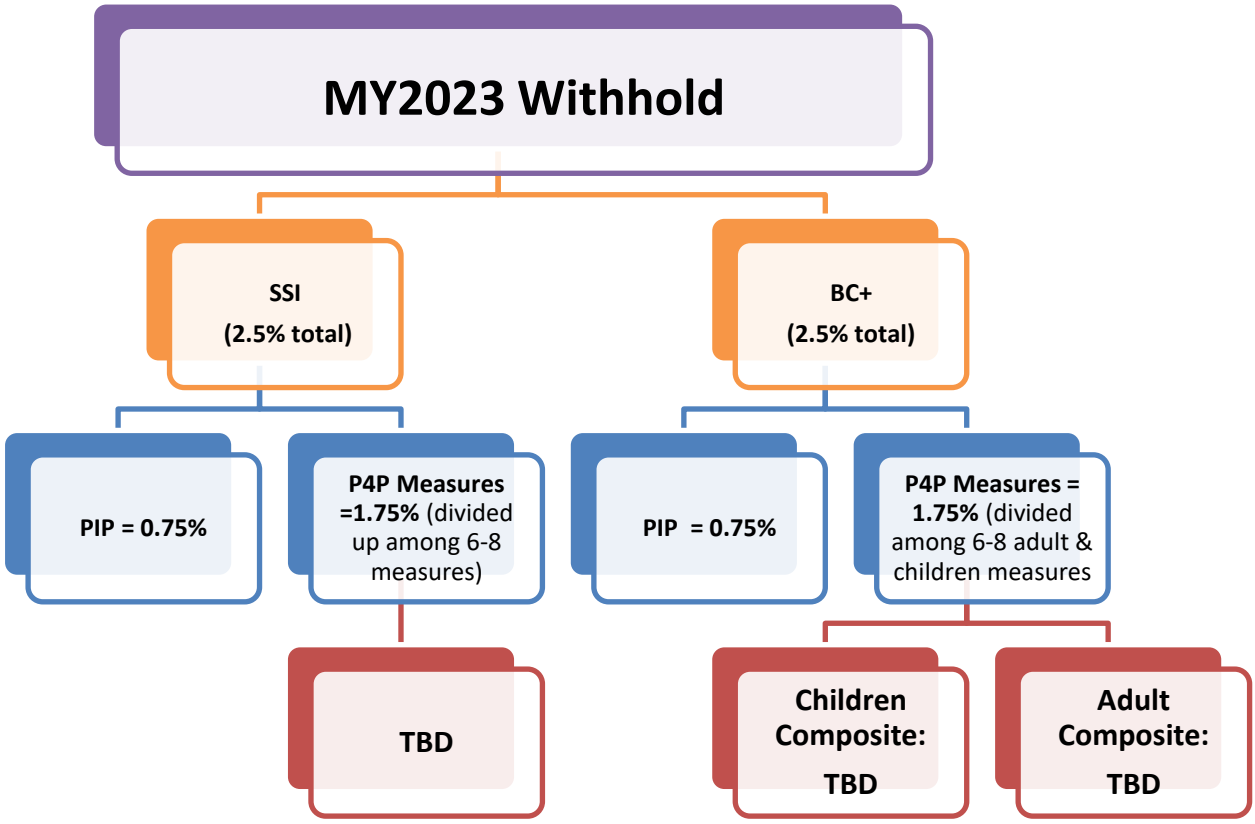
DMS will set performance targets for each measure and HMO. Results will be calculated for all 6 Regions collectively, unless otherwise specified.

Measures, Withhold and Targets

1. The DMS uses **HEDIS measures** for its P4P initiative.
   There will be no deviations from HEDIS specifications. Refer to HEDIS Technical Specifications published by NCQA for details of specific measures.
2. The MY2023 upfront **withhold rate** is 2.5%. The withhold will apply to capitation for BC+ and SSI, including administrative payments.
   a. BC+:
      - 0.75 % withhold will be assigned to a PIP for reducing disparities
      - 1.75% withhold will be assigned to HEDIS measures

   b. SSI:
      - 0.75 % withhold will be assigned to a PIP for reducing disparities
      - 1.75% withhold will be assigned to HEDIS measures

   c. An HMO can also earn a bonus.



3. MY2023 P4P targets for BC+ and SSI

MY2023 baselines for HEDIS measures are set using the latest available MY2021 HEDIS state-wide averages and the MY2021 national HEDIS percentiles as published in the Quality Compass.

This approach provides:

- A level starting point for all HMOs
- Transparent targets shared in advance
- Consistent targets that do not change mid-year

The table below lists for each P4P measure:

- 2021 national HEDIS percentiles
- 2021 state average
- The composite applicable to the measure
- Targets for earning P4P points (further explained in the P4P Methodology section)

MY2023 HMO P4P Measures, Composites and Targets:
Table will be updated when measures are selected, and Quality Compass released with revised benchmarks.

P4P Methodology

This section will be updated pending finalization of P4P measure selection.

The same methodology applies to all composites.

1. **Points:**
   Based on its level of performance, an HMO can earn **0 to 4 points** for each measure (more points are better) in the following manner:
   - 4 points if the HMO's rate is at or above the national 75th percentile for that measure
   - 3 points at or above the national 67th percentile for that measure
   - 2 points at or above the national 50th percentile for that measure
   - 1 point - When the State average for a measure falls below the national 50th percentile for that measure, then an HMO can earn 1 point for results at or above the State average
   - No points below the 50th national percentile for that measure

2. **Earning back the withhold:**
   a. An HMO can receive between 0 and 4 points for each measure
   b. The maximum # of points each composite can have
      = 4 points per measure * # of measures in the composite
   c. Each measure in a composite is weighted equally
   d. Actual total # of points for each composite for an HMO
      = Sum of HMO's points for all measures in that composite
   e. % of points earned for each composite
      = {Actual total # of points received / Maximum # of points} * 100
   f. % of withhold earned back
      = % of points earned by the HMO for the composite

3. **Small denominators:** 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.

4. **Example:** The following **hypothetical example** using the **children's health composite** illustrates the above methodology:
   - The children's health composite has 3 measures. Therefore, the maximum # of points an HMO can earn for this composite = 3*4 = 12 points.
   - Assume that the table below represents the results and points for this composite:

Measure	MY2023 Target for:				Points earned based on ***hypothetical*** performance of:		
	4 points	***3 points***	***2 points***	***1 point***	***HMO A***	***HMO B***	***HMO C***
CIS - Combo 3	>=75.2%	>=73.2%	>=71.1%	N/A	78% = 4 points	74% = 3 points	68% = 0 points
IMA - Combo 2	>=43.1%	>=40.9%	>=36.9%	N/A	48% = 4 points	45% = 4 points	44 % = 4 points
LSC	>=81.0%	>=79.2%	>=73.1%	N/A	86% = 4 points	77% = 2 points	88% = 4 points
				Total points earned	**12**	**9**	**8**
				% of points earned	= 12 / 12 **= 100%**	= 9 / 12 **= 75%**	= 8 / 12 **= 66.7%**

- **HMO A** earns a total of 12 points for all measures in this composite, shown in the second–to-last row of the above table. This represents 12/12 = 100% of the maximum points for this composite. Therefore, the HMO will earn back 100% of its withhold for this composite, shown in the last row of the above table.
- **HMO B** earns a total of 9 points for all measures in this composite, shown in the second - to-last row of the above table. This represents 9/12 = 75% of the maximum points for this composite. Therefore, the HMO will earn back 75% of its withhold for this composite, shown in the last row of the above table.
- **HMO C** earns a total of 8 points for all measures in this composite, shown in the second–to-last row of the above table. This represents 8/12 = 66.7% of the maximum points for this composite. Therefore, the HMO will earn back 66.7% of its withhold for this composite, shown in the last row of the above table.

Bonus

The P4P initiative has two separate pools for withhold – one for BC+, and the other for SSI; correspondingly, there are two separate bonus pools. The bonus would reward HMOs that demonstrate high quality by meeting **all** their targets and earning back their **full** withhold for each pool, separately. An HMO must meet **all** the following requirements:

1. To earn a BC+ bonus, an HMO must earn back 100% of its BC+ withhold for all applicable composites; to earn an SSI bonus, an HMO must earn back 100% of its SSI withhold for all applicable composites.
2. The HMO has reported data for **all** the P4P and non-P4P WICR measures.
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.

MY2023: Minimum # of applicable P4P measures for bonus eligibility	
BC+	4 out of 5 P4P measures (pending finalization of number of measures)
SSI	4 out of 5 P4P measures (pending finalization of number of measures)

The total bonus earned by any plan will be the total withheld amount forfeited by other plans, capped at the total capitation P4P HEDIS withhold amount for the plan. (Max bonus is = to P4P HEDIS withhold)

Separate bonus pools for BC+ and for SSI will be formed by the respective portion of withhold not earned back (i.e., forfeited) by HMOs. 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 their members in the **denominator** for all applicable measures, subject to the bonus limits. This approach addresses key methodological issues such as**:**

- Variation in the # of members enrolled, i.e., the difference between large and small HMOs, which is accounted for by the limit on bonus.
- Variations in the performance of HMOs.
- Variation in performance of HMOs due to the proportion of enrolled members with specific medical conditions, which is accounted for using the denominator (not the total HMO enrollment) in calculating the bonus.

Example of bonus calculations

Assume the total bonus pool is worth $2 million for the Measurement Year. Also assume that the table below represents HMOs that 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**

IV. HMO Report Card

The HMO Report Card serves multiple purposes:

- Informational tool for Medicaid members to select an HMO. The Report Card is included in the HMO Enrollment Selection Tool.
- Comparisons of HMO performance compared to state and national benchmarks

Currently HEDIS measures are included on the Report Card. See Appendix E for information on the pool of measures available **(note: Draft until a later version of this Quality Guide)**. The list of measures that are planned for inclusion in the 2023 results HMO Report Card may be revised due to changes in priority areas, revisions to the measure specifications from the measure stewards (e.g., NCQA), and member feedback.

The HMO Report Card is publicly available on ForwardHealth[3]. Reports cards will be published in the 4th quarter of the HMO submission year (e.g., the 2023 results Report Card, using data submitted to DMS in June 2024, will be published in Q4 2024).

Star Rating System and Methodology

1. Each HMO will receive 1 to 5 stars for each quality measure in each area of care based on how well it performed compared to NCQA's Quality Compass - National Medicaid HEDIS percentiles.

# of Stars	Explanation
★★★★★ = Excellent	HMO was among the top 25 percent of all Medicaid HMOs in the nation; it performed better than 75 percent (or, 3/4th) of all Medicaid plans.
★★★★ = Very Good	HMO was among the top 33 percent of all Medicaid HMOs in the nation; it performed better than 67 percent (or, 2/3rd) of all Medicaid plans.
★★★ = Good	HMO was among the top 50 percent of all Medicaid HMOs in the nation; it performed better than 50 percent (or, half) of all Medicaid plans.
★★ = Fair	HMO was below the national average; it performed better than 33 percent (or, 1/3rd) of all Medicaid plans in the nation.
★ = Poor	HMO performed in the lowest 1/3rd of all Medicaid plans in the nation.

2. Areas of care are assigned a star rating in ½ star increments based on the **average star rating for each quality measure within that Area of Care**.

[3]https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/Home.htm.spage

From	To	Number of stars assigned
4.75	5	5
4.25	4.74	4.5
3.75	4.24	4
3.25	3.74	3.5
2.75	3.24	3
2.25	2.74	2.5
1.75	2.24	2
1.25	1.74	1.5
0.75	1.24	1
0	0.74	0.5

The table below is a placeholder. Area of Care and measure selection will depend on analysis of data received in the 4th quarter. Table will be updated in a future version.

Area of Care	Quality Measure	BadgerCare Plus	Medicaid SSI
Staying Healthy	Breast Cancer Screening (HEDIS – BCS-AD)	Applicable	Applicable
	Childhood Immunization (HEDIS – CIS, Combo 3)	Applicable	N/A
	Cervical cancer screening (HEDIS- CCS-AD)	Applicable	Applicable
	Chlamydia screening, ages 16-20 (HEDIS-CHL-CH)	Applicable	Applicable
	Adolescent immunization (HEDIS-IMA-CH) – all except combo 2	Applicable	N/A
	Lead screening in children (HEDIS-LSC)	Applicable	N/A
Living With Illness	Diabetes – HbA1c testing (HEDIS – CDC)	Applicable	Applicable
	Controlling Blood Pressure (HEDIS – CBP)	Applicable	Applicable
Mental Health Care	Anti-depressant Medication Management – Continuation (HEDIS – AMM)	Applicable	Applicable
	Alcohol and Other Drug Dependence – Engagement (HEDIS – IET)	Applicable	Applicable
	Follow-up after Hospitalization for Mental Illness (HEDIS – FUH-30)	Applicable	Applicable
	Follow-up after ED visit for alcohol and other drug abuse or dependence (HEDIS-FUA)	Applicable	Applicable
	Follow-up after ED visit for mental illness (HEDIS-FUM)	Applicable	Applicable
	Adherence to antipsychotic medications for individuals with schizophrenia (HEDIS-SAA)	Applicable	Applicable
Hospital and ED Care	Plan all-cause readmissions (HEDIS-PCR)	Applicable	Applicable

Area of Care	Quality Measure	BadgerCare Plus	Medicaid SSI
Pregnancy & Birth-related Care	Prenatal care (HEDIS – PPC)	Applicable	N/A
	Postpartum care (HEDIS – PPC)	Applicable	N/A

3. Overall numerical quality score is calculated as an average score, calculated as **the total sum of each individual measure divided by the total number of individual measures.**

Example of BadgerCare + Report Card

BadgerCare Plus HMO	Hospital and ED	Living with Illness	Mental Health	Pregnancy & Birth	Staying Healthy	Overall (out of 5)
HMO a	★★★★	★★★★½	★★★½	★★★	★★★	3.4
HMO b	★★	★★½	★★★★½	★★½	★★★★½	3.8
HMO c	★★★★★	★★★★	★★½	★★	★★½	2.8
HMO d	★★★★★	★★★★	★★★½	★★★★★	★★★★	4
HMO e	★	★★	★★½	★	★★★½	2.4
All Wisconsin BC+ HMOs	★★★½	★★★½	★★★½	★★½	★★★½	3.2

Example of SSI Report Card

Medicaid SSI HMO	Hospital and ED	Living with Illness	Mental Health	Staying Healthy	Overall (out of 5)
HMO a	★★★★★	★★★★½	★★½	★½	2.7
HMO b	★	★★★★½	★★★★	★★★★½	3.7
HMO c	★	★½	★★★	★★★	2.7
HMO d	★	★★★	★★★★	★★★★½	3.3
HMO e	★★★★★	★★★★★	★★★½	★★½	3.6
All Wisconsin SSI HMOs	★★½	★★★★½	★★★★½	★★★	3.2

V. Potentially Preventable Readmissions (PPR)

1. Goal of the HMO PPR Initiative

The goal of the HMO PPR Initiative is to reduce Potentially Preventable Readmissions (PPRs) for Wisconsin Medicaid members served by HMOs. Excess readmission chains relative to benchmarks suggest an opportunity to improve patient outcomes and to reduce costs through discharge planning, coordination of care across sites of service, and/or other improvements in the delivery of care.

2. PPR Software

PPR calculation is based upon a clinical algorithm created by 3M. Many items are evaluated when determining clinical relationships such as DRGs, diagnosis codes, procedure codes and duration between discharge and admission. Certain conditions are excluded when classified as "intrinsically clinically complex." 3M provides a detailed User Guide documenting the algorithm to hospitals and plans who purchase the software.

The 3M PPR software analyzes all admissions for HMO members, and classifies each admission into one of the following categories:

- Only Admission (OA): A claim that is not a potentially preventable readmission and is not followed by a potentially preventable readmission (at any hospital) within 30 days
- Initial Admission (IA): A claim that is not a potentially preventable readmission and is followed by a potentially preventable readmission (at any hospital) within 30 days
- Readmission (RA): A claim that is a potentially preventable readmission associated with an initial admission within 30 previous days
- Exclusion: A claim that is excluded from measurement under 3M's clinically-based algorithm exclusions (example: clinically complex cases)

Qualifying Admissions are defined as OAs + IAs.

3. PPR Calculation Methodology

a. **All Wisconsin Medicaid recipients** for whom an HMO receives a capitated payment are included in the PPR model.

b. Actual IAs and benchmark IAs (readmission chains) are aggregated for each HMO to determine risk adjusted readmission chain rates for each HMO.

c. **Readmission chain rates for HMOs** will be calculated using only the HMO data from all providers, since DMS's focus is on the impact of HMO-specific initiatives with their providers, recognizing that there will be variation across providers and HMOs.

d. Readmission chain rates for **Fee-for-Service (FFS)** hospitals will be calculated using only the FFS data. All FFS hospitals are included in FFS PPR calculations, though only

providers with over 25 qualifying admissions are eligible to participate in the FFS incentive program.

e. **Benchmark IAs** are risked adjusted and calculated for each HMO based on the statewide managed care average rate of IAs by APR-DRG and Severity of Illness combination. Further adjustments to benchmark IAs are made to account for differences in patient age and secondary mental health diagnosis. Benchmark IAs by HMO are aggregated based on the HMO's mix of services (based on APR-DRG and patient age) and volume. Analysis by DMS's vendor, Milliman, has not shown a variation in the ABRs across the Medicaid rate regions.

f. Benchmark IAs are compared to actual IAs for each HMO. "Excess" IAs are actual IAs exceeding benchmark IAs. Measuring HMO performance based on actual vs. risk adjusted benchmark IAs (readmission chains) enables DMS to compare HMO performance even when there are differences in enrollment, population morbidity, inpatient volume, and inpatient case mix.

g. Providers who are paid on a per diem basis are included in the development of statewide managed care average rate of IAs by APR-DRG and Severity of Illness, though these providers are exempted from PPR-based incentives/penalties. Behavioral admissions are included in calculations of PPRs.

h. PPR calculations for an HMO are based on all providers serving the Medicaid members of that HMO. There are no minimum thresholds for the number of Qualifying Admissions for HMOs.

i. **Attribution of PPR chains to an HMO**: HMO PPR analyses are based on encounter data only, which eliminates the impact of mid-chain switching between HMO and FFS eligibility. Similar to the hospital PPR initiative, the HMO that is assigned the start of a PPR chain is also assigned the PPR if a recipient changes HMOs within a PPR chain (like recipients switching hospitals for hospital PPR chain). However, such instances are rare; a DMS analysis found that less than 0.5% of HMO PPR chains involved a switch between HMOs by a member.

j. **Transfer of patients across facilities**: All transfers across facilities are handled in a similar manner, regardless of diagnoses (e.g., behavioral health, others).

k. **Social determinants**: There are no current adjustments for social determinants in PPR calculations. HMOs have the flexibility to collect social determinants data using ICD-10 codes and report the data to DMS. DMS is open to reviewing how social determinants data submitted by HMOs can be used in PPR calculations.

l. For PPR related to **SSI Care Management only**: When a patient who has previously not had an upfront screening (i.e., no G9001 code billed yet for that year) is so identified while being admitted for inpatient care, it presents an opportunity to conduct the upfront screening (G9001 billing code) and to provide transition care services (G9012 code). Both the codes cannot be billed in the same month even though both services can be provided in the same month in this scenario. DMS will track such service events.

The HMOs are also expected to track such service events separately, and to bring them to DMS's attention in a timely manner. HMOs will have an opportunity to review the preliminary results from DMS and provide feedback DMS if such services are missed in the calculations.

m. An HMO may dispute DMS's PPR calculations by sending a written communication to the DHSDMSBRS@dhs.wisconsin.gov mailbox no later than 30 days after receiving DMS's PPR calculations. After 30 days, the HMO waives the right to dispute the PPR calculations. Any dispute communication should be accompanied by supporting documentary evidence that shows how the HMO's PPR calculations are different than DMS's calculations.

4. HMO PPR Initiative

a. **Population in scope:**
MY 2023 HMO PPR initiative will focus on BadgerCare Plus readmissions only.

b. **PPR measure:**
= % reduction in Actual to Benchmark Ratio (ABR) in the Measurement Year (MY) ABR compared to the Baseline ABR.

$$\%\ reduction\ in\ ABR = \frac{[Baseline\ ABR - MY\ ABR]}{[Baseline\ ABR]}$$

HMO ABR value used for baseline is shown in row *K* in the HMO PPR report shared by DMS with the HMOs.
Numerator = QAs with associated PPR (Initial Admissions), shown in row *E1* in the HMO PPR report
Denominator = Benchmark PPR Chains, shown in row *I* in the HMO PPR report.

Note: The Wisconsin Medicaid PPR measure is different than the CMS All-Cause Readmission measure in that the PPR measure is based on actual Wisconsin Medicaid utilization; its exclusions for clinically complex conditions such as neonatal births and certain malignancies make it more relevant and actionable for Wisconsin Medicaid HMOs and providers. The CMS measure is aligned with Medicare utilization data.

c. **Baseline for 2023:**
MY 2021 HMO-specific ABR performance results will be used to establish the baselines for MY2023, reflecting each HMO's actual # of PPRs as a ratio of its expected # of PPRs:

- Baseline ABR = 1 means that in the baseline year, the HMO's PPR performance was the same as the state-wide average PPR performance
- Baseline ABR < 1 means that in the baseline year, the HMO's PPR performance was below (i.e., better than) the state-wide average PPR performance
- Baseline ABR > 1 means that in the baseline year, the HMO's PPR performance was above (i.e., worse than) the state-wide average PPR performance.

d. **Upside incentive**
For MY 2023, HMOs will have an upside incentive only, with no PPR-related

penalties. DMS will set aside a pool of funds as upside incentive, to be distributed among HMOs that meet their targets for % reduction in their ABR, as value-based payments. HMOs that do not meet the target will not receive any PPR incentive funds.

There is no PPR withhold currently for HMOs. In future years the initiative may include an upside (bonus) and downside (penalties) arrangements, in alignment with the FFS PPR initiative for hospitals.
Note: Per 42 CFR 438.6(b)(2), "…Contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound…". The 105% limitation will be applicable cumulatively across various incentives such as P4P and PPRs.

e. **DMS guidance to HMOs:**
- DMS expects HMOs to identify how best to work with their providers. DMS would like to see HMOs develop their plans to reduce PPRs jointly with their providers; HMOs may also choose to collaborate with other HMOs to identify joint focus areas to reduce PPRs with common providers.
- Throughout the state, no health plan holds a majority (over 50%) of the state Medicaid market share. DMS believes this incentivizes larger HMOs to work with smaller HMOs so that, together, the relative market share encompasses a greater share of the population for plans pursuing statewide approaches.

f. **Methodology for targets and incentives:**
Each HMO will be eligible to earn a prorated share of the incentive pool based on two factors - its relative share of the total qualifying admissions in the baseline year, and its % reduction in ABR. DMS will publish the # of qualifying admissions in the baseline year for each HMO.

DMS has established three tiers of HMOs, based on their baseline ABRs:

- Tier 1 = High performance HMOs, with baseline ABR <= 0.95
- Tier 2 = Middle performance HMOs, with baseline ABR => 0.96 but <= 1.05
- Tier 3 = Low performance HMOs, with baseline ABR => 1.06

The Tiers above also create confidence intervals for the methodology.

HMOs with low ABR (<= 0.85):
DMS recognizes that HMOs, which already have low ABRs, might face a limited ability to improve their performance year over year. Therefore, if an HMO's ABR is <= 0.85 in **both the baseline year and the Measurement Year**, DMS will deem that HMO eligible to participate in the incentive even if it does not show any % improvement in PPR in the MY over the baseline year. Such an HMO will be eligible for 100% of its potential incentive share. There will be no graduated scale for this adjustment.

All HMOs are expected to improve their PPR performance over time, as reflected in the reduction in their ABR in the MY compared to their baseline year. However, in recognition of a potentially different starting point for each HMO, each tier will have different targets for earning the Potential Incentive Share, as shown in the table below:

Table: PPR Reduction Targets

Proportion of Potential Incentive Share that is earned by the HMO	**Baseline Tier (based on ABR)**		
	Tier 1 - High performance HMOs	***Tier 2 - Middle performance HMOs***	***Tier 3 - Low performance HMOs***
100%	5% or more	7% or more	10% or more
75%	3% to 4.9%	4% to 6.9%	7% to 9.9%
50%	1% to 2.9%	2% to 3.9%	4% to 6.9%
25%	0.25% to 0.9%	0.5% to 1.9%	1.5% to 3.9%

Interpreting the "PPR Reduction Targets" table:

1. Identify the tier in which an HMO was placed, based on its baseline year ABR.
2. Calculate the % reduction in ABR and find the cell (in white, in the table above) that corresponds to that % reduction. For example, the relevant cell for a Tier 1 HMO with a 6% reduction in ABR is the top left cell (in white) in the above table, which reads "5% or more."
3. Identify the proportion of the Potential Incentive Share that is earned by the HMO based on its % reduction in ABR, by looking left in the first column.

   Example: A Tier 1 HMO with a 6% reduction in ABR would earn its full potential incentive share (earned proportion = 1.00, or 100%).

   Alternatively, if that HMO reduced its ABR by, e.g., 3.5% instead of 6%, it would earn 0.75 proportion (=75%) of its potential incentive share; if that HMO reduced its ABR by, e.g., 0.7%, it would earn 0.25 proportion (=25%) of its potential incentive share.

Illustrative example - HMO PPR methodology (hypothetical data)

- Assume there are 5 HMOs as shown in Column 1 of the table below, each with the total number of qualifying admissions in the **baseline** year shown in Column 2.

HMO PPR - HYPOTHETICAL EXAMPLE									
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8	Col. 9	Col. 10
HMO	**Qualifying admissions in Baseline Year**	**Share of qualifying admissions**	**Potential Incentive share**	**Baseline ABR**	**Tier in baseline year**	**MY ABR**	**% reduction from baseline**	**Potential Incentive earned**	**$ Incentive earned**
A	40,000	25.3%	$1,265,823	1.090	Low	0.940	13.76%	100%	$ 1,265,823
B	20,000	12.7%	$632,911	1.030	Middle	0.980	4.85%	75%	$ 474,684
C	50,000	31.6%	$1,582,278	1.040	Middle	1.070	-2.88%	0%	$ -
D	15,000	9.5%	$474,684	0.940	High	0.920	2.13%	50%	$ 237,342
E	33,000	20.9%	$1,044,304	0.840	High	0.850	-1.19%	100%	$ 1,044,304
State-wide	**158,000**	**100.00%**	**$5,000,000**	**1.000**			**3.14%**	**60%**	**$ 3,022,152**

- Column 3 shows the relative share of each HMO in the total qualifying admissions in the baseline year. E.g., HMO A has 40,000 / 158,000 = 25.3% share.
- Assume DMS sets aside $5 million as the total incentive pool (shown in the last row for Column 4). Column 4 shows the **potential share** of the incentive pool each HMO could earn, based on its share of qualifying admissions. For example, HMO A could earn up to 25.3% of $5 million = $1,265,823.
- Hypothetical baseline ABR for each of the 5 HMOs are shown in Column 5.
- Column 6 shows the tier in which each HMO is placed, based on its baseline ABR.
- Column 7 shows the ABR achieved in the Measurement Year (MY).
- Column 8 shows each HMO's % ABR reduction = (Column 5 – Column 7) / Column 5.
- Column 9 shows the % of the Potential Incentive earned, based on the "PPR Reduction Targets" table, discussed above. For example, HMO A earned 100% of its Potential Incentive, while HMO D earned 50% of its Potential Incentive. HMO E earned 100% of its potential share because its ABR was <= 0.85 for both, the baseline year and the MY, regardless of its reduction in ABR.
- Column 10 shows the $ value of incentive earned (= Column 9 * Column 4).

For the next cycle, the MY ABR (Column 7) would become the baseline for the HMO, so that HMOs could move across tiers. In the above example, HMO A started in the Low Tier (ABR = 1.09) in the baseline year but would be classified in the High Tier (ABR <= 0.95) in the next cycle.

PPR incentive payments for MY 2023 will be disbursed in 2024, after data for the full MY have been analyzed.

g. **Sharing the incentives with Providers:**

- HMOs may keep up to 15% of PPR incentive earned for their administrative expenses. The remaining incentives must be shared with their providers, including hospital and non-hospital providers. HMOs are welcome to discuss their specific incentive sharing ideas with DMS.
- HMOs have flexibility in negotiating how they share incentive dollars with their providers. DMS believes that the HMOs' interest in ensuring a hospital is not penalized by one HMO while being rewarded by another will encourage HMOs to coordinate and collaborate in their approach for designing the incentive program for hospitals.
- HMOs may set up their own staff teams (clinical and non-clinical) to work on PPR reduction, and such related expenses will be counted as "provider sharing" for MY2023, provided the HMOs can demonstrate that infrastructure spending on such internal teams is directly related to and relevant for PPR reductions. Examples of such activities include discharge planning, medication reconciliation on discharge, follow-up in out-patient settings following discharge, home visits, etc. HMOs can count the actual hours (and related dollars) worked by their internal teams on PPR reduction, as provider sharing for MY2023. HMOs are required to maintain supporting documentation of time and expenses to share with DMS upon request. HMOs will be asked to attest to the accuracy of such expenses. HMOs are welcome to discuss their plans for establishing internal teams with DMS.

h. **Data reports:**

HMOs will receive quarterly PDF summary reports for the HMO and associated hospitals, a list of members with PPRs, and a data dashboard for their members for their providers; HMOs will not receive data for patients not enrolled in that HMO. HMOs will receive a summary PPR report comparing their performance to other plans, a list of recipients with one or more PPR within their claims dataset, and one PDF per hospital in the claims dataset that had a PPR attributed to the plan. 3M licensing contract prohibits DMS from sharing grouped PPR claims with plans. PPR software can be purchased from 3M using default settings. DMS intends to share **three types of PPR reports** with HMOs, to balance the timeliness and completeness of such reports (also see the table below):

1. **Working data reports**: HMOs will receive "working data" reports about 6 weeks after the end of a measurement period (e.g., a quarter). Working data reports are meant to provide recent information to HMOs, while recognizing that such reports will have incomplete data because not enough "claims run-out" time would have passed since the end of the measurement period.
2. **Preliminary annual reports**: HMOs will receive "preliminary" annual reports about 4.5 months after the end of the measurement year. These reports will have most of the full measurement year's data, though there might be minor additions before the final annual reports are issued.
3. **Final annual reports**: HMOs will receive the "final" annual reports about 7.5 months after the end of the MY. HMOs will have the opportunity to provide feedback to

DMS between receiving the preliminary annual reports and the final annual reports. Any PPR-related incentives will be calculated based on the final annual reports.

Table: Schedule of PPR reports for HMOs

Measurement period	Working data available on:	Preliminary annual report available on:	Final annual report available on:
2022			
1/1 – 3/31	5/15/2022	5/15/2022 (data for MY2021)	N/A
4/1 – 6/30	8/15/2022	N/A	N/A
7/1 – 9/30	11/15/2022	N/A	N/A
10/1 – 12/31	2/15/2023	N/A	N/A
2023			
1/1 – 3/31	5/15/2023	5/15/2023 (data for MY2022)	N/A
4/1 – 6/30	8/15/2023	N/A	N/A
7/1 – 9/30	11/15/2023	N/A	9/15/2023 (data for MY2022)
10/1 – 12/31	2/15/2024	N/A	N/A

VI. SSI Care Management

The SSI Care Management Initiative is designed to improve overall quality of life for medically complex SSI members, incorporating high-touch, high-intensity interventions. HMOs are responsible for establishing a team-based care management model. The care structure and care management model must assure coordination and integration of all aspects of all SSI members' health care needs. The HMO must also promote effective communication and shared decision-making between care management team and the member regarding the member's care.

DMS will employ the following mechanisms for monitoring its SSI Care Management initiative.

- Utilization analysis of specific care management services (**G codes and modifiers related to needs assessment tiers)**.
- **Qualitative External Quality Review Organization (EQRO) Review** of SSI Care Management Process Quality.

Each of the above are described in further detail below. Performance results on either mechanism may be included in the HMO Report Card or other publicly available quality reports (e.g., Annual EQR Technical Report, Managed Care Quality Strategy).

Utilization Analysis

DMS will analyze the encounter data with G codes submitted by the HMOs to evaluate how well the care management services delivered by the HMOs meet the program objectives. Data reported will be analyzed to compare HMOs performance and to evaluate overall effectiveness of the initiative.

Reports will be completed throughout the year by DMS and shared with HMOs.

The SSI Care Management Billing Guide is available on the ForwardHealth Portal at: https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Reimbursement_and_Capitation/Home.htm.spage#ssicmbg

DMS (or selected vendor) will calculate the following data points and measures using G Codes and appropriate Modifiers (TG, TF, and none):

1. Care Planning (CP1) = % of new members had a care plan within 90 days of enrollment
2. Needs Stratification (NS1) = % of members enrolled each month assigned to the Wisconsin Interdisciplinary Care Team (WICT)
3. Needs Stratification (NS2) = % of members enrolled over the year assigned to WICT
4. Needs Stratification (NS3) = average # of months a member assigned to WICT
5. Needs Stratification (NS4) = % of members enrolled each month assigned to Medium stratum
6. Needs Stratification (NS5) = % of members enrolled over the year assigned to Medium stratum

7. Needs Stratification (NS6) = % of members enrolled each month assigned to Low stratum (=combining all strata below Medium)
8. Needs Stratification (NS7) = % of members enrolled over the year assigned to Low stratum (=combining all strata below Medium)
9. Transition Care (TC1) = % of discharges who received transition care follow-up
10. Transition Care (TC2) = % of discharges who received transition care follow-up within 5 days

Step	Data Reporting Description
Care Planning	**<u>New members</u>** *(enrolled after 1/1/2023; not enrolled in the same HMO for the past 6 months or longer):* **(CP1): % of new members with care plans within 90 days of enrollment** = # of new members with care plans within 90 days of enrollment / # of new members with 90+ days of continuous enrollment ***Calculated quarterly*** *by DMS using code G9001* DMS will track timeliness of care planning, from date of enrollment; Calculated quarterly by DMS using code G9001; Histograms for 90 days, 120 days, 150 days and beyond.
Needs Stratification	Use Care Management (G) codes 9002, 9006, 9007 or 9012; ***Calculated by month*** *by DMS after data submission deadline:* **<u>WICT (up to 5% of SSI membership)</u>** *Data point 1: # of unique members each month with any <u>G code + TG modifier</u> (= WICT stratum)* **(NS1): % enrollment in WICT for each month** = Data point 1 / total # of members enrolled for that month (Assumption: each member in WICT receives at least one WICT related service each month) **(NS2): Average % enrollment in WICT over last 12 months** = Sum of Data point 1 over last 12 months / # of total member months over last 12 months **(NS3): Average # of months in WICT over last 12 months** = Sum of # of months each unique member had a WICT code over 12 months / # of unique members with WICT services at any time over last 12 months *Create a histogram for NS3 (# of months and corresponding # of members)*

Step	Data Reporting Description
	<u>Medium stratum (next highest after WICT)</u> *Data point 2: # of unique members each month with any G code + TF modifier (= Medium stratum). There is no payment difference between TF modifier and no modifier.* **(NS4): % enrollment in Medium stratum for each month** = Data point 2 / total # of members enrolled for that month **(NS5): Average % enrollment in Medium stratum over last 12 months** = Sum of Data point 2 over last 12 months / total # of member months over last 12 months **<u>Lower stratum (all combined after Medium)</u>** *Data point 3: # of unique members each month with any <u>G code + no modifier</u> (= all combined Lower stratum). There is no payment difference between TF modifier and no modifier.* **(NS6): % enrollment in Lower stratum for each month** = Data point 3 / total # of members enrolled for that month **(NS7): Average % enrollment in Medium stratum over last 12 months** = Sum of Data point 3 over last 12 months / total # of member months over last 12 months
Transition Care	**Calculation annually** by DMS *Data point 4: Total # of discharges from inpatient stay during the reporting period* *Data point 5: Total # of discharges during the reporting period with an associated follow-up Transition of Care encounter measures by the presence of procedure code G9012 or in its absence, G9001; respective # of days between discharge and follow-up* *Create a frequency distribution / histogram for data point 5 (# of days for follow-up)* **(TC1): % of all discharges from inpatient stay with a follow-up Transition Care service** = Sum of Data point 5 / Data point 4 **(TC2): Timeliness of Transition Care (within 5 days of discharge)** = % of all discharges from inpatient stay with a follow-up Transition Care service within 5 days of discharge = Data point 5 within 5 days / Data point 4

Qualitative EQRO Review of SSI Care Management Process Quality

The focus of the EQRO SSI Care Management Review process is to ensure HMO compliance with the SSI Care Management requirements defined in the BC+ and Medicaid SSI HMO Contract. For its review, the EQRO will use MMIS enrollment data to create samples for each HMO to identify members in WICT (Wisconsin Interdisciplinary Care Team), medium, and low strata. The sample size will be an 80% confidence rate based on the HMO's entire enrollment.

Reviews will be spread out throughout the year with one to two HMOs reviewed per month. The 2023 reviews will measure the 12 months preceding the review. For example, if the review is scheduled for January 2023, the review period will be January 1, 2022-December 31, 2022; if the review is scheduled July 2023, the review period is July 1, 2022-June 30, 2023.

EQRO Review
Care Plan Development - *EQRO will focus on assessing whether HMOs are complying with the Care Plan development requirements in the HMO Contract.* a. Is the Care Plan developed based on a screening conducted within 60 days of new member's enrollment in the HMO or annually for current members? The HMO should not use screening data greater than 30 days old. b. Is the screening comprehensive as identified in the BC+ and SSI HMO Contract? This includes: i. The member's chronic physical health needs (including dental) ii. The member's chronic mental and behavioral health needs (including substance abuse) iii. The member's perception of their strengths and general well-being iv. If the member has a usual source of care v. Any indirect supports the member may have vi. Any relationships the member may have with community resources vii. Any immediate and/or long-term member concerns about their overall well-being (including SDOH) viii. Activities of daily living assistance needs ix. Instrumental activities of daily living assistance needs c. Is the Care Plan an evidence-based plan of care that: i. Identifies the member's needs, including a) Formal and informal supports b) Chronic conditions and acute illnesses c) Mental and behavioral health conditions d) Dental care needs e) Medications taken by the member; any concerns with member's understanding and use of medications f) Additional supports needed to conduct activities of daily living or instrumental activities of daily living g) Social determinants of health

EQRO Review
ii. Defines specific goals that the member wants to achieve and that are appropriate to address his/her needs? (Yes/No) iii. Has a system to prioritize member's goals appropriately, based on urgency, member's engagement and the ability to lead to positive outcomes and impact for the member? (Yes/No) iv. Describes the interventions that will be implemented to address the member's needs and their sequence? (Yes/No)
WICT –*To answer the questions below, the EQRO will request the HMO's WICT policies and procedures, care management records for the members in the sample, and WICT meeting minutes. EQRO will focus on assessing whether HMOs are complying with the Care Plan development requirements in the BC+ and SSI HMO Contract.* a. Well-functioning WICT - Is there evidence of a well-functioning interdisciplinary team: i. A minimum of two licensed health care professionals with adequate expertise across medical, mental, and behavioral health, and social determinants of health, with access to resources such as pharmacists, physicians, psychiatrists, dieticians, rehabilitation therapists, and substance abuse specialists as needed? ii. A Core Team meets weekly to discuss their entire shared case load? (Yes/No) iii. A Core Team that coordinates regularly with the member's PCP, medical specialists, behavioral health specialists, dental providers, and other community resources as driven by the member's care plan? (Yes/No) *The EQRO will look for evidence in the member's care plan and care management notes. The EQRO will also describe who within the WICT is conducting the meetings and the meeting location (i.e., meeting at the member's home or meeting the member elsewhere). Alternate format visits (telehealth, telephonic, etc.) in lieu of the required face-to-face visits during a public health emergency where DMS has granted flexibility on contract expectations will be scored as "met with waiver" as long as all other requirements are met.* b. Face-to-face requirement – Is there evidence in the member's Care Plan that at least one member of the WICT Core Team meets at least once a month face-to-face with the member to discuss a need identified in his/her care plan? (Yes/No) *During a public health emergency when DMS has granted flexibility regarding the contract requirements, the face-to-face member meeting may occur via telehealth (phone or video) visit. If the member does not have access to telehealth visits, the care management notes and/or care plan must reflect the cancellation or inability to meet face-to-face.* *Note: A WICT member's face-to-face meeting with their community-based case manager (e.g., Comprehensive Community Services or Community Support Programs case manager) may meet the face-to-face requirement if the community-based case manager has a close, collaborative relationship with the WICT Core Team that is demonstrated in the member's care plan and includes*

EQRO Review
reciprocal communication between the WICT Core Team and the community-based case manager. The face-to-face visit must be documented as a care coordination and monitoring activity in the member's care plan. c. Graduation i. Does the member's Care Plan clearly identify the criteria for the member to graduate from the WICT? (Yes/No) ii. Is there evidence of the WICT being a short-term (i.e., less than 12 months) intensive intervention? (Yes/No) iii. Once the member is ready to graduate from the WICT, is there evidence that the WICT is coordinating the transition of members to a lower intensity of care management? (Yes/No)
Care Management Service Delivery – *EQRO will look for evidence in the care management records of members in the sample to address the questions below.* a. Compliance with the Care Plan - Are services, including any planned follow-ups with members, delivered according to the Care Plan? b. Member-centric Care i. When implementing the Care Plan, does the HMO regularly assess the member's readiness to change and their level of engagement in meeting their Care Plan goals? (Yes/No) ii. As part of Care Plan implementation, is there evidence that the HMO is adhering to its own policies and procedures regarding frequency of contact with members per strata? Member contacts or attempts using alternate formats in lieu of a HMO-required face-to-face will be scored as "met with waiver." iii. Is there evidence that the HMO is asking members if their needs are being addressed? (Yes/No) c. Social Determinants (SD): i. Is follow-up on SD documented in the Care Plan? (Yes/No) ii. Did the HMO go beyond simple referrals and sharing phone numbers to provide community resources with the member? (Yes/No) *EQRO will describe HMO efforts to address social determinants including how they are working collaboratively with community resources or utilizing Community Health Workers* d. Behavioral Health i. Does the HMO follow-up to address the member's behavioral health needs identified in the Care Plan? (Yes/No)
Care Plan Review & Update –*The EQRO will review the HMO's care management policies and procedures as well as the member's care management records to assess compliance with the review and updates to the Care Plan requirements defined in the current BC+ and SSI HMO Contract.* a. Is the HMO reviewing and updating the Care Plan based on the criteria defined in the BC+ and SSI HMO Contract? (Yes/No) b. At least once per calendar year? (Yes/No)

EQRO Review
c. According to the HMO's policies and procedures for reviewing Care Plans and re-stratifying members? (Yes/No) d. Whenever the member is not responsive to the Care Plan or whenever the member frequently transitions between care settings? (Yes/No) e. Does the HMO re-stratify members after a change in the level of care or critical events such as a discharge from emergency departments, hospitals and nursing homes or rehabilitation facilities, as appropriate? (Yes/No)
Discharge Follow-up / Transitional Care – *EQRO will review member care management records to determine compliance with the transitional care contract requirements.* a. Did the HMO's transitional care follow-up meet the transitional care requirements in the applicable BC+ and SSI HMO Contract? b. How was the HMO notified of the member's hospital admission? c. Was the follow-up in-person, via interactive video, or over the phone? d. Is there evidence that the transitional care follow-up included: i. Medication reconciliation, documented in the member's care management notes, conducted either by the hospital or the HMO? ii. A review with members of (a) the discharge information prepared by the hospital and (b) the member's medications and their medication schedule? e. Did the HMO assist members with scheduling appointments with other health care providers after discharge? (Yes/No) f. Did the follow-up occur within five business days of hospital discharge? (Yes/No) *The EQRO will describe if the HMO is receiving real-time notifications about the member's hospital admission and if the HMO is using WISHIN or EPIC Care Everywhere for transitional care. The EQRO will also describe how the HMO is conducting the follow-up and assess whether the HMO is helping members schedule follow-up appointments, understand their medication schedule, and implement their treatment plan.*

Additional note:

- The EQRO recommends that HMOs document events such as sharing care plans through mail and/or secure portal (upon confirming the member has an accessible account), completing medication reconciliation, and conducting follow-up activities in their systems. Without documentation, the EQRO will be unable to confirm that such activities took place.
- The EQRO also recommends that in addition to reviewing a medication list with the member, a HMO's medication reconciliation should include the following: review of pre and post discharge medications and dosages, confirmation of absence of duplication of medications, confirmation of absence of drug interactions/contraindications, and accuracy of all continued, discontinued, new, and altered medications and dosages.

VII. Performance Improvement Projects

HMOs are required to submit two Performance Improvement Projects (PIP) each year to DMS. See the 2022-2023 BadgerCare Plus and Medicaid SSI HMO contract requirements for PIPs in Article X, (J).

- HMOs must work with DMS' EQRO to meet specific project requirements defined by CMS. CMS's Quality of Care External Quality Review Protocol[4] may be a helpful reference in developing the PIP and completing the template.
- The PIP proposal and final report template can be found in Appendix J. The PIP proposal is due to DMS December 1, 2022. After DMS approval, the HMO's project will operate for CY 2023. The final PIP report is due to DMS and the EQRO by July 1, 2024. Both the proposal and final report must be submitted using the provided template.
- EQRO PIP Standards and PIP Scoring Example may be useful tools for HMOs in developing their PIP proposals and final reports. See Appendices H and I.
- Additional guidance on PIPs is available through the HMO PIP Trainings[5] on proposals (PIP 101 Training) and validation (PIP 102 Training).

PIPs as a Strategic Initiative

To align with Federal and State priorities and to further improvements in health outcomes for all Medicaid members in Wisconsin, HMOs must focus on reducing health disparities in the populations the HMOs serve for both PIPs.

Wisconsin DMS recognizes that improving health equity is a foundational strategy for improving the health of Wisconsin's residents, improving the experience of care for Wisconsinites, and containing costs of care to ensure affordability. Persistent and systematic differences in health outcomes for different Wisconsin populations are well documented, and a key component of Healthiest Wisconsin 2020[6]. CMS also specifically requires reduction in health disparities to be a part of the State's quality strategy[7].

Health disparities are often related to the conditions in which people are born, live, grow, work, and age – also called the drivers of health (DOH). In fact, "upwards of 70% of health outcomes are driven by factors beyond health care."[8] Economic resources and geographical location have a proven sizable impact on health outcomes, and so partnerships between communities and

[4] CMS Quality of Care External Quality Review Protocol: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf
[5] HMO PIP Trainings: https://vimeo.com/showcase/9388305
[6] https://www.dhs.wisconsin.gov/hw2020/report.htm
[7] https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/state-quality-strategies/index.html
[8] Health Care Steps Up to Social Determinants: Current Context

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 is foundational to any effort to eliminate disparities.

PIP Structure

2023 will be the **final year** that PIPs are part of the P4P withhold. As detailed in the table below, each HMO will have one PIP per member population subject to a P4P withhold of 0.75% for each population .

	PIP 1	PIP 2
HMO serves BC+ and SSI	0.75% BC+ P4P withhold Topic Continuation of 2022 BC+ Prenatal and Postpartum (PPC) Topic (Year 4) **-or-** Clinical or non-clinical topic of HMO choice focused on reducing a health disparity among BC+ population	0.75% SSI P4P withhold Topic Continuation of 2022 SSI Health Disparity Topic (Year 3) **-or-** Clinical or non-clinical topic of HMO choice focused on reducing a health disparity among SSI population
HMO serves SSI only	0.75% SSI P4P withhold Topic Continuation of 2022 SSI Health Disparity Topic (Year 3) **-or-** Clinical or non-clinical topic of HMO choice focused on reducing a health disparity among SSI population	No P4P withhold Topic Clinical or non-clinical topic of HMO choice focused on reducing a health disparity among SSI population
HMO serves BC+ only	0.75% BC+ P4P withhold Topic Continuation of 2022 BC+ Prenatal and Postpartum (PPC) Topic (Year 4) **-or-** Clinical or non-clinical topic of HMO choice focused on reducing a health disparity among BC+ population	No P4P withhold Topic Clinical or non-clinical topic of HMO choice focused on reducing a health disparity among BC+ population

P4P Earn Back Requirements

To earn back the .75% P4P withhold, HMOs must comply with federal PIP requirements **AND** implement new, innovative activities as strategies for improvement. All activities must be meaningful and must:

- Include efforts at the HMO-level, with a clinic(s) or provider network, and the larger community (i.e., community-based organization and/or partnerships) that address social determinants of health (SDOH);
- Address identified gaps related to health disparities and SDOH;
- Go beyond basic administrative activities (e.g., reminder calls or postcards); **AND**
- Incorporate member and stakeholder feedback.

Topic Selection

HMOs may continue the same topic from the 2022 health disparities reduction PIPs into 2023 or may propose an alternate topic aimed at reducing an identified health disparity in the population the HMO serves.

If the HMOs chooses to continue the same topic from the 2022 health disparities reduction PIPs, the proposal must

1. Include the rationale or objective(s) for continuing the PIP.
2. Include justification if discontinuing any required elements from 2022, if applicable. Reference the 2022 HMO Quality Guide for details on required elements.[9]
3. Include an additional evidence-based intervention or significant modification of existing intervention, including how it will likely lead to improved outcomes for the target population.

   Examples:
   - Activities to address gaps or barriers identified in Determinants of Health (DOH) assessments, such as expansion of screening in additional populations with high social risk factors, establishing partnerships in geographic regions where identified barriers exist, or closing loops in referral systems.
   - Projects to address DOH identified in needs assessment and/or action plan.
   - Scaling up any previous activities to additional providers, community-based organizations, or target groups.

HMOs should select a topic where there is an identified health disparity in the target population, based on rural/urban residence, race, ethnicity, sex, gender, age, primary language, disability, etc., regardless of overall performance in the measure. This is not limited to P4P

[9] HMO Quality Guide https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/Home.htm.spage

measures but could include any performance measure (including a HEDIS measure, a care management measure, or CAHPS result).

HMOs can reference the structure of 2020-2022 Health Disparities PIPs to replicate or expand elements that were effective at reducing health disparities, such as partnerships with clinics and community-based organizations.

Note: *Per federal requirements, HMOs must complete one clinical and one non-clinical project. Since 2023 is a transition year for PIPs, HMOs may have two clinical topics in 2023 but must have one clinical and one non-clinical project in 2024.*

Suggested Topics

DMS has identified some suggested PIP topics. HMOs may propose alternative performance improvement topics during the preliminary topic selection summary process, but topic selection is subject to DMS approval.

Suggested Clinical Topics

1. Adolescent immunizations
2. Antidepressant medication management
3. Asthma management
4. Blood lead testing
5. Breast cancer screening
6. Cardiovascular care
7. Childhood immunizations
8. Childhood obesity interventions
9. Dental care
10. Diabetes management
11. Emergency department utilization
12. Well Child Visits
13. Medication reconciliation upon discharge
14. Behavioral health and substance abuse screenings and management
15. Tobacco cessation
16. Hypertension management
17. Preventable hospital readmissions

Suggested Non-Clinical topics

1. Access and availability of services
2. Member satisfaction
3. Social Determinants of Health
4. Implementation of Culturally and Linguistically Appropriate Services (CLAS Standards)
5. Care coordination
6. SSI Care Management

VIII. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

The **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** survey was developed by the Agency of Health Research and Quality (AHRQ) to capture information from members about their experiences with their health plan and health care providers. Per the Children's Health Insurance Program Reauthorization Act (CHIPRA), CMS requires states to survey children in the Children's Health Insurance Program (CHIP) program annually via CAHPS.

DMS uses the CAHPS to survey both fee-for-service and HMO member experience and satisfaction with care. The survey is performed annually for children in the BadgerCare Plus and CHIP populations. The CAHPS survey is used as part of HEDIS reporting, and survey data is shared with CMS.

DMS administers CAHPS through a certified vendor, surveying approximately 1,650 fee-for-service members, and 1,650 members from each HMO. Results are stratified by language (English, Spanish, and Hmong) and CHIP, Medicaid, HMO, and FFS populations. DMS follows NCQA protocols for the survey, including:

- Using current CAHPS version 5.1 child questionnaire.
- Eligibility criteria for sampling:
  - Continuous enrollment for the last 6 months prior to 12/31/2022
  - No more than one-month enrollment gap.
- Using mixed survey outreach methodology by survey vendor:
  - Questionnaire mailings
  - Reminder mailings
  - Multiple follow-up call attempts

Please note that HMOs are not prohibited from administering the CAHPS survey to their membership. Although DMS is not requiring collection of HMO-administered CAHPS results at this time, DMS may request information in the future.

IX. OB Medical Home

Under Article IV, D of the current HMO contract, HMOs serving Milwaukee, Kenosha, Ozaukee, Racine, Washington, Waukesha, Dane, and Rock Counties are required to implement Obstetric Medical Home (OBMH) care models. This initiative is part of DMS' larger Healthy Birth Outcomes initiative and has a goal of improved care management and service delivery for high-risk pregnant HMO members in geographic areas with high and disparate rates of poor birth and maternal outcomes.

In addition to the contract language, DMS maintains OBMH resources for HMOs and providers on the ForwardHealth Portal here: https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Managed_Care_Medical_Homes/Home.htm.spage.

The HMO must submit a report evaluating its OB Medical Home initiative to DMS every year using a survey link provided by DMS.

EQRO Review

- The focus of the EQRO OB Medical Home Review process is to ensure HMO and clinic compliance with OBMH requirements defined in the BC+ and Medicaid SSI HMO contract.
- On a quarterly basis, EQRO identifies members enrolled in the OBMH with delivery dates occurring during the previous quarter. HMOs are required to provide the EQRO with the member's medical records, and the EQRO uses a review tool and review guidelines to evaluate compliance with OBMH requirements.
- For questions on the OBMH registry, which is a tool used by participating HMOs and OBMH provider sites, contact DMS's EQRO. The OBMH registry log-in, user guides, and help desk are available on the EQRO website: https://apps.metastar.com/apps40/commercial/OBMH/OBMH/Login.aspx

HMOs are paid an incentive of $1,000 (to pass through to the OB medical home site) per enrolled OBMH member whose care was in compliance with OBMH requirements. An additional $1,000 bonus is paid for those members who met the OBMH requirements and the person giving birth had a healthy birth outcome.

HMOs may contact DHSOBMH@wi.gov with questions on the OBMH requirements.

X. NCQA Accreditation

Accreditation Requirements

In March 2021, DMS issued a policy memo to HMOs indicating that all HMOs must receive NCQA Health Plan Accreditation (HPA) by December 31, 2023. See **Appendix K** for a copy of the memo. Additionally, all HMOs must achieve either Multicultural Health Care Distinction (MHCD) or Health Equity Accreditation (HEA) by December 31, 2023, as part of DMS' goals to improve members' access to culturally and linguistically appropriate care.

> **Note:** NCQA is transitioning the MHCD to HEA. HMOs that have MHCD as of December 31, 2023 are expected to work with NCQA on transitioning to HEA.

HMOs must submit quarterly progress reports on their work towards accreditation using the NCQA Quarterly Progress Report template. Once the HMO has achieved HPA and either MHCD or HEA, the HMO is not required to submit quarterly progress reports.

Accreditation Deeming

As part of DMS' Medicaid Managed Care Quality Strategy, DMS and the EQRO complete an accreditation deeming plan, which includes a crosswalk to federal requirements to DMS oversight, EQRO oversight, and NCQA accreditation.[10]

HMOs with NCQA accreditation are deemed as having met specific federal requirements, and additional DMS or EQRO review is waived as being duplicative. These HMOs are not subject to a comprehensive compliance standards review by the EQRO. For federal requirements that are not met via accreditation, the EQRO conducts a focused accreditation review to bridge the gap for specific standards.

Accreditation status of HMOs is included on DMS's public website, and accreditation review activities are described in the EQRO's annual report, which is published on DMS's public website and submitted to CMS annually, per federal requirements.

[10] HMO Accreditation Deeming Plan can be accessed on the ForwardHealth Portal here: https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/word/2021_2023_HMO_Accreditation_Deeming_Plan.docx.spage

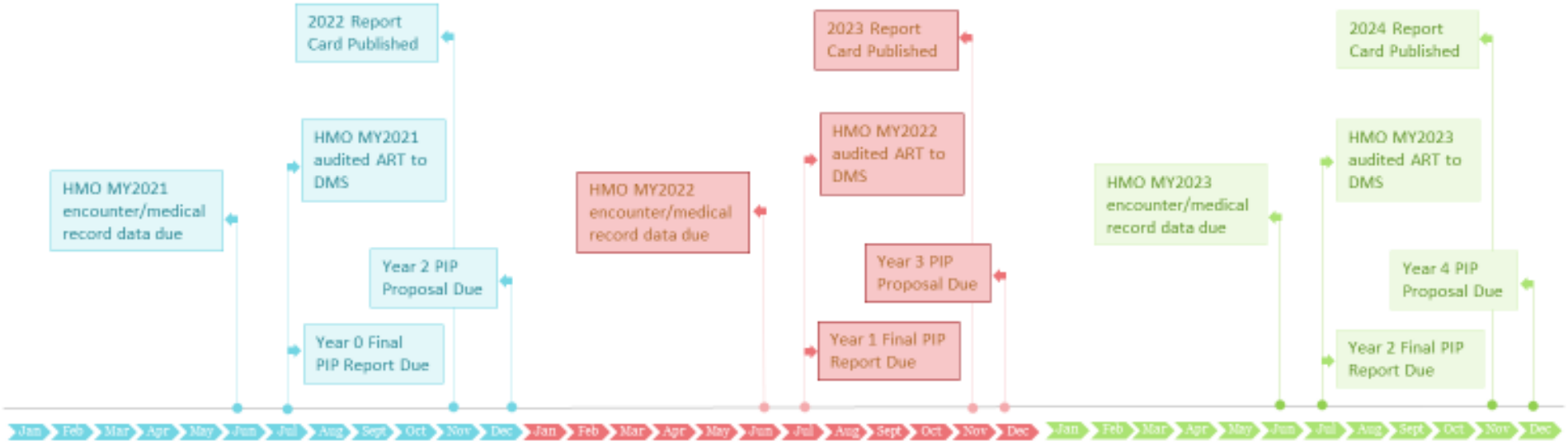
Appendix A: Timeline of Quality Initiative

Timelines for 2023 Quality Initiatives	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
WICR												
HMO 2022 final encounter/medical record data to DHS (used for any DMS-calculated measures)												
HMO audited review tables (ARTs) of 2022 data to DMS												
Patient-Level files for 2022 data to DMS												
DMS calculates and submits Core Set measures to CMS												
2024 WICR measure selection process (CMS Core Set published December)												
P4P												
HMO 2022 final encounter/medical record data to DHS (used for any DMS-calculated measures)												
HMO audited review tables (ARTs) of 2022 data to DMS												
Prelim results from DHS												
HMO feedback												
Final results from DHS												
Report Card												
HMO audited review tables (ARTs) of 2022 data to DMS												
DMS calculates star ratings and shares with HMOs												
DMS publishes 2022 report card												
PPR												
Prelim results												
Final results												
PIP												
MY2022 HMO final report to EQRO												
MY2024 HMO PIP proposal due												
CAHPS												
DMS's vendor delivers CAHPS survey												
Vendor receives results data; Data submitted to AHRQ												
Final report delivery												
2023 Planning: Submit new questions for NCQA consideration to vendor for Round 1 Deadline												
DMS presents 2023 results to HMO; 2024 Planning: Submit new questions for NCQA consideration to vendor for Round 2 Deadline												
NCQA Accreditation												
Quarterly progress report due												
Other												
Fee-For-Service (FFS) Data Extract Request												

Appendix B: 3 Year Quality Initiative and Data Reporting Cycle

3 Year Cycle

Quality Initiative and Data Reporting



Year 1 *(2022)*

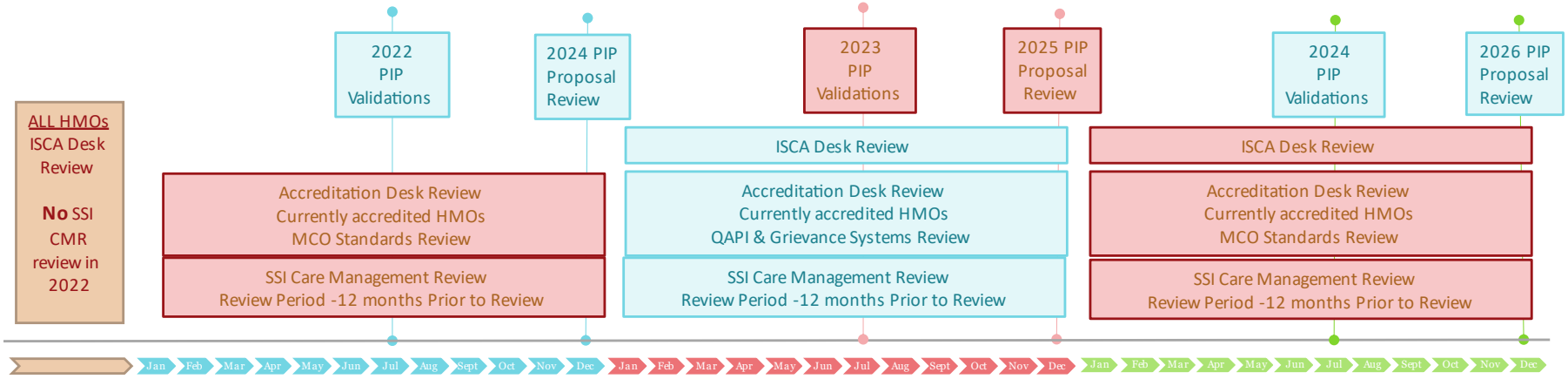
Year 2 *(2023)*

Year 3 *(2024)*

Appendix C: 3 Year EQRO Review Cycle

3 Year EQRO Review Cycle

- The Accreditation Desk Review and SSI Care Management Review will occur concurrently for each HMO. All HMO reviews will be scheduled throughout calendar year 2023.
- Each year one third of HMOs will have Information System Capabilities Assessment (ISCA) review each year starting in 2024



(2022) Year 1 (2023) Year 2 (2024) Year 3 (2025)

Appendix D: Deliverables Due Dates & Submission Instructions

Frequency	Report/Deliverable	Due Date	Template
QUARTERLY REPORTS *1st Quarter: (Jan-March); 2nd Quarter: (April – June); 3rd Quarter: (July – Sept); 4th Quarter: (Oct– Dec)*			
NCQA Accreditation Reports	• NCQA Accreditation - Quarterly Progress Report • Email to DHSDMSHMO@dhs.wisconsin.gov		NCQA Quarterly Progress Report Template
ANNUAL REPORTS			
OB Medical Home Annual Report	• Previous calendar year report due to DMS via survey • Due date is the first Monday of June	6/1/2023	Survey link to be provided at later date
HMO final MY2022 encounter/medical record data to DHS	• Data files and documents are to be submitted to DMS via the SFTP server • All electronic data files must include the year and health plan name in the file name • Email to DHSDMSHMO@dhs.wisconsin.gov and to VEDSHMOSupport@wisconsin.gov notifying them when the files (test files or production files) have been placed on the SFTP server	6/30/2023	File layout for the Patient Level Detail files will be published in revised Quality Guide as Appendix 60 days after CMS publishes 2023 Core Sets.
Performance Improvement Project (PIP) Final Project Report	• Email to DHSDMSHMO@dhs.wisconsin.gov and EQRO contact by password protected email attachment • Report due on the 1st business day of July for the prior calendar year	• 7/3/2023 2022 projects • 7/1/2024 2023 projects	Appendix J
HMO audited review tables (ARTs) of 2022 data to DHS	• Data files and documents are to be submitted to DMS via the SFTP server • All electronic data files must include the year and health plan name in the file name • Email to DHSDMSHMO@dhs.wisconsin.gov and to VEDSHMOSupport@wisconsin.gov notifying them when the files (test files or production files) have been placed on the SFTP server	7/31/2023	

Frequency	Report/Deliverable	Due Date	Template
Fee-For-Service (FFS) Data Extract Request	HMOs must submit to DMS a file with member IDs for whom HMOs would like to receive FFS data	11/15/2023	
Initial Performance Improvement Project (PIP) Proposal	• Email to DHSDMSHMO@dhs.wisconsin.gov and EQRO contact by password protected email attachment • Topic Selection on first business day of December for the next calendar year	12/1/2023	Appendix J
SSI Care Management	N/A		
PPR	N/A		
CAHPS	N/A		

Appendix E: Table of Measures: WICR, P4P, and Report Card

Table pending final Core Set lists from CMS, discussion of P4P measures with HMOs, and ongoing discussions with HMOs about Report Card measures. This 2022 table is provided as an example based on current state.

BadgerCare Plus			
Adult Measures	**WICR**	**P4P**	**Report Card**
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-AD)	✓		
Antidepressant Medication Management (AMM-AD)	✓		✓
Breast Cancer Screening (BCS-AD)	✓		✓
Controlling High Blood Pressure (CBP-AD)	✓		✓
Cervical Cancer Screening (CCS-AD)	✓		✓
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control level (>9%) (CDC/HPC)	✓		✓
Chlamydia Screening in Women Ages 16 to 20 (CHL-AD)	✓		✓
Colorectal Cancer Screening (COL-AD)	✓		
Follow-Up After ED Visit for Substance Use (FUA-AD)	✓		✓
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	✓		✓
Follow-Up After ED Visit for Mental Illness (FUM-AD)	✓		✓
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	✓		
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	✓		✓
Plan All-Cause Readmissions (PCR-AD)	✓		✓
Prenatal and Postpartum Care (PPC)	✓	✓	✓
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	✓		✓
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	✓		
Child Measures	**WICR**	**P4P**	**Report Card**
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-CH)	✓		
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	✓		
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	✓		
Asthma Medication Ratio: Ages 19 to 64 (AMR-AD); Ages 5 to 18 (AMR-CH)	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	✓		
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	✓		
Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	✓		✓
Childhood Immunization Status (CIS-CH)	✓	✓ Combo 3	✓

Follow-Up After ED Visit for Substance Use: Ages 13 to 17 (FUA-CH)	✓		✓
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	✓ 30 days		✓
Follow-Up After ED Visit for Mental Illness: Ages 6 to 17 (FUM-CH)	✓		✓
Immunizations for Adolescents (IMA-CH)	✓	✓ Combo 2	✓
Lead Screening in Children (LSC)		✓	✓
Prenatal and Postpartum Care (PPC)	✓	✓	✓
Well-Child Visits in the First 30 Months of Life (W30-CH)	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	✓		
Child and Adolescent Well-Care Visits (WCV-CH)	✓		

SSI			
Adult Measures	**WICR**	**P4P**	**Report Card**
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-AD)	✓		
Antidepressant Medication Management (AMM-AD)		✓	✓
Breast Cancer Screening (BCS-AD)	✓		✓
Controlling High Blood Pressure (CBP-AD)	✓		✓
Cervical Cancer Screening (CCS-AD)	✓		✓
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%); Poor Control level (>9%) (CDC -HPC-AD)	>9.0% control	<8.0% Control	✓
Chlamydia Screening in Women Ages 16 to 20 (CHL-AD)	✓		✓
Colorectal Cancer Screening (COL-AD)	✓		
Follow-Up After ED Visit for Substance Use (FUA-AD)	✓		✓
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	✓	30 days	✓
Follow-Up After ED Visit for Mental Illness (FUM-AD)	7 days	30 days	✓
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	>9.0% control		
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	✓		✓
Plan All-Cause Readmissions (PCR-AD)	✓		✓
Prenatal and Postpartum Care (PPC-AD)	✓		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	✓		✓
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	✓		
Child Measures	**WICR**	**P4P**	**Report Card**
Asthma Medication Ratio: Ages 19 to 64 (AMR-AD); Ages 5 to 18 (AMR-CH)		✓	
Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	✓		✓
Prenatal and Postpartum Care (PPC-CH)	✓		

Appendix F: Data Reporting Specifications

In addition to the WICR initiatives, HMOs shall submit all other NCQA HEDIS measures results to DMS. Results will be used for potential future baseline measurements.

a. HMOs not NCQA accredited shall submit all HEDIS measures or submit a letter to DMS clearly stating the reason(s) for its inability to generate a specific measure along with its regular HEDIS data submission to DMS.

b. Those measures where the primary collection method is a survey are not included in WICR; however, HMOs are still responsible for reporting.

c. There is not a fiscal penalty if HMOs fail to submit a non-WICR measure.

Any HEDIS performance measures retired or modified by NCQA that impact the HMO initiatives during MY2023 will be discussed and documented in a Quality Guide amendment.

HMOs should report results using **standard HEDIS specifications** for all measures unless specified below. **Table below will be updated once CMS Core Set is released.**

Reported Measure	DMS Specific Instructions
MSC-AD	If an HMO is not NCQA accredited or is in the process of accreditation, it is not required to report this measure. Although not WICR in 2023, there will be an expectation in the future with as NCQA health plan accreditation is required by December 31, 2023.
FUH-CH	HEDIS and CMS use slightly different technical specifications. HMOs should report results using standard HEDIS specifications for this measure.
AMB-CH	HMOs must use the standard HEDIS technical specifications to report only the ED Visits portion for this measure.
WCC-CH	HMOs must use the standard HEDIS technical specifications to report only the BMI Assessment for children and adolescents.

Data Submission and Reporting for BC+ and SSI

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

HMOs are required to submit the following for MY2023:

a. **Data Filled Workbook, including Audit Review Table (ART) format** downloaded from the NCQA IDSS site (with evidence that the auditor lock has been applied) as an Excel file. HMOs must provide to DMS the **denominators and numerator for each measure**.

b. The Audit Report produced by a NCQA Licensed HEDIS Auditor.

c. For HEDIS measures with age stratification and other sub-populations, HMOs are asked to report results in the IDSS and ART tables by age strata and other sub-populations as well as for the overall population.

NCQA has added Electronic Clinical Data Systems (ECDS), as a new reporting method for some of their HEDIS measures. NCQA-accredited HMOs may be required to submit measures to NCQA in ECDS format, however, DMS is requiring HMOs continue to submit ART results.

2. Electronic submission requirements:

a. Data files (including ARTs) and documents are submitted to DMS via the Secure File Transfer Protocol (SFTP) server.

b. All electronic data files must include the year and health plan name in the file name.

c. Send an email to DHSDMSHMO@dhs.wisconsin.gov and to VEDSHMOSupport@wisconsin.gov notifying them when the files (test files or production files) have been submitted to the SFTP server.

3. Public Reporting

For MY2023, all health plans are required 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.

4. Patient Level Detail files are required

Although NCQA requires only Medicare plans to submit patient-level data for HEDIS measures that are calculated and submitted by HMOs, HMOs must submit Medicaid patient-level data for HEDIS measures calculated by HMOs' HEDIS vendors. The purpose of such patient-level files is to allow DMS and HMOs to conduct various analyses, including identification of health disparities.

DMS will provide HMOs with a template for data submission to include patient-level measure data that details patient's Medicaid ID # and available demographic data such as age, gender, race, ethnicity, preferred language, disability status, and location of residence.

In creating these files, HMOs can apply the same HEDIS value sets for diagnosis, procedure and other codes used by their HEDIS vendors to calculate the measure results. HMOs have the discretion to retain additional information they might use in future analyses.

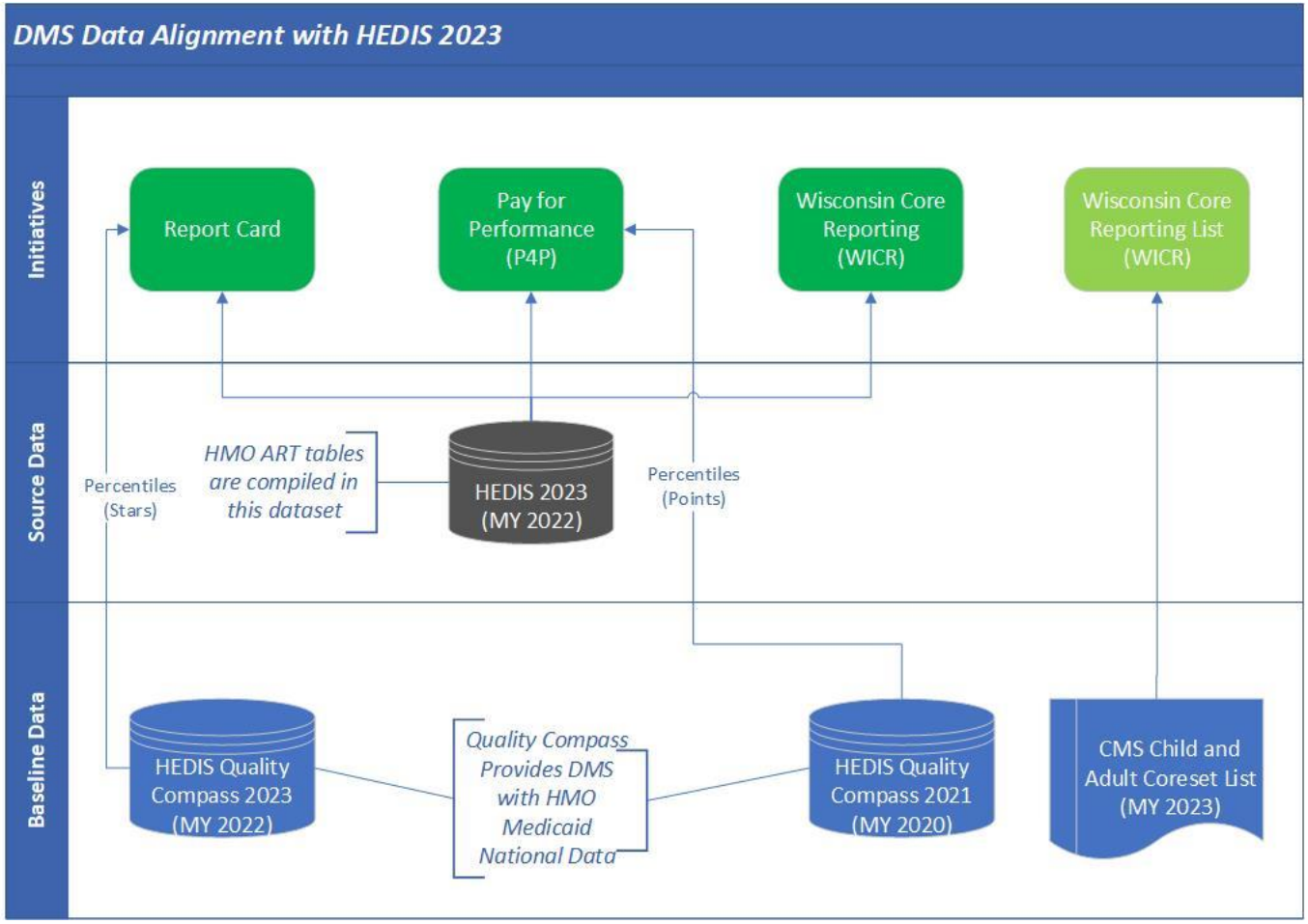
5. Fee-For-Service (FFS) data for BC+ All Regions

At the end of each year, DMS provides 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 Measurement Year data due to the associated time lags.*

HMOs must submit a file with member IDs for whom HMOs would like to receive FFS data to DMS no later than November 15, 2023.

Appendix G: Flow Chart on HEDIS and Data Alignment

This visual is for illustrative purposes to show the connection between HMO HEDIS results and the various 2023 Quality Guide initiatives, as well as the connection to NCQA and CMS. No action is required by HMOs for this Appendix.



Appendix H: PIP Standards and Scoring

PIP Standards and Scoring

Reference: Department of Health and Human Services. Centers for Medicare and Medicaid Services. (2019). *EQR Protocol 1Validation of Performance Improvement Projects; A Mandatory EQR-Related Activity.* Retrieved from https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf

#	Standards
1	**PIP Topic** 1.1 The PIP topic was selected through a comprehensive analysis of MCO enrollee needs, care, and services. 1.2 The PIP topic considered performance on the CMS Child and Adult Core Set measures (if applicable). 1.3 The selection of the PIP topic considered input from enrollees or providers who are users of, or concerned with, specific service areas. 1.4 The PIP topic addressed care of special populations or high priority services. 1.5 The PIP topic aligned with priority areas identified by DHS and/or CMS.
2	**PIP Aim Statement** 2.1 The PIP aim statement clearly specified the improvement strategy. 2.2 The PIP aim statement clearly specified the population for the PIP. 2.3 The PIP aim statement clearly specified the time period for the PIP. 2.4 The PIP aim statement was concise. 2.5 The PIP aim statement was answerable. 2.6 The PIP aim statement was measurable.
3	**PIP Population** 3.1 The project population was clearly defined in terms of the identified PIP question. 3.2 If the entire MCO population was included in the PIP, the data collection approach captured all enrollees to whom the PIP question applied.
4	**Sampling Method** 4.1 The sampling frame contained a complete, recent, and accurate list of the target PIP population. (The sampling frame is the list from which the sample is drawn.) 4.2 The sampling method considered and specified the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error. 4.3 The sample contained a sufficient number of enrollees taking into account non-response.

	4.4 The method assessed the representativeness of the sample according to subgroups, such as those defined by age, geographic location, or health status. 4.5 Valid sampling techniques were used to protect against bias.
5	**PIP Variables and Performance Measures** 5.1 The variables were adequate to answer the PIP question. 5.2 The performance measure assessed an important aspect of care that will make a difference to enrollees' health or functional status. 5.3 The performance measures were appropriate based on the availability of data and resources to collect the data. 5.4 The measures were based on current clinical knowledge or health services research. 5.5 The performance measures monitored, tracked, and compared performance over time; and informed the selection and evaluation of quality improvement activities. 5.6 The MCO considered existing measures such as CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, or AHRQ measures. 5.7 The MCO developed new measures based on current clinical practice guidelines or health services research if there were gaps in existing measures. 5.8 The measures captured changes in enrollee satisfaction or experience of care. 5.9 The measures included a strategy to ensure inter-rater reliability (if applicable). 5.10 The process measure is meaningfully associated with outcomes (if applicable).
6	**Data Collection Procedures** *General* 6.1 The PIP design specified a systematic method for collecting valid and reliable data that represents the population in the PIP. 6.2 The PIP design specified the frequency of data collection. 6.3 The PIP design clearly specified the data sources. 6.4 The PIP design clearly defined the data elements to be collected. 6.5 A list of data collection personnel and their relevant qualifications was provided. 6.6 The data collection plan linked to the data analysis plan to ensure that appropriate data would be available for the PIP. 6.7 The data collection instruments allowed for consistent and accurate data collection over the time periods studied. 6.8 Qualitative data collection methods were well-defined and designed to collect meaningful and useful information from respondents (if applicable).

	Administrative Data Sources (if applicable) 6.9 If inpatient data was used, the data system captured all inpatient admissions/discharges. 6.10 If primary care data was used, primary care providers submitted encounter or utilization data for all encounters. 6.11 If specialty care data was used, specialty care providers submitted encounter or utilization data for all encounters. 6.12 If ancillary data was used, ancillary service providers submitted encounter or utilization data for all services provided. 6.13 If LTSS data was used, all relevant LTSS provider services were included. 6.14 If EHR data was used, patient, clinical, service, or quality metrics were validated for accuracy and completeness as well as comparability across systems. *Medical Record Review (if applicable)* 6.15 A list of data collection personnel and their relevant qualifications was provided. 6.16 For medical record review, interrater and intra-rater reliability was described. 6.17 For medical record review, guidelines for obtaining and recording the data were developed.
7	**Data Analysis and Interpretation of PIP Results** 7.1 The analysis was conducted in accordance with the data analysis plan. 7.2 The analysis included baseline and repeat measurements of project outcomes. 7.3 The analysis assessed the statistical significance of any differences between the initial and repeat measurements. 7.4 The analysis accounted for factors that may influence the comparability of initial and repeat measurements. 7.5 The analysis accounted for factors that may threaten the internal or external validity of the findings. 7.6 The PIP compared the results across multiple entities, such as different patient subgroups, provider sites, or MCOs. 7.7 PIP results and findings were presented in a concise and easily understood manner. 7.8 To foster continuous quality improvement, the analysis and interpretation of the PIP data included lessons learned about less-than-optimal performance.
8	**Improvement Strategies** 8.1 The selected improvement strategy was evidence-based, that is, there was existing evidence (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables).

	8.2 The strategy was designed to address root causes or barriers identified through data analysis and quality improvement processes. 8.3 The rapid-cycle PDSA approach was used to test the selected improvement strategy. 8.4 The strategy was culturally and linguistically appropriate. 8.5 The implementation of the strategy was designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices). 8.6 Building on the findings from the data analysis and interpretation of PIP results, the PIP assessed the extent to which the improvement strategy was successful and identify potential follow-up activities.
9	**Significant and Sustained Improvement** 9.1 The same methodology was used for baseline and repeat measurements. 9.2 There was quantitative evidence of improvement in processes or outcomes of care. 9.3 The reported improvement in performance was likely to be a result of the selected intervention. 9.4 There is statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention. 9.5 Sustained improvement was demonstrated through repeated measurements over time.

Appendix I: PIP Scoring Example

#		Standards & Elements	Yes/No (1=yes, 0=no)	Total Points Possible (per standard)	Points Received (per standard)	Percentage Met (per standard)
1	**PIP Topic**			5	5	100.0%
	1.1	The PIP topic was selected through a comprehensive analysis of MCO enrollee needs, care, and services.	**1**			
	1.2	The PIP topic considered performance on the CMS Child and Adult Core Set measures (if applicable).	**1**			
	1.3	The selection of the PIP topic considered input from enrollees or providers who are users of, or concerned with, specific service areas.	**1**			
	1.4	The PIP topic addressed care of special populations or high priority services.	**1**			
	1.5	The PIP topic aligned with priority areas identified by DHS and/or CMS.	**1**			
2	**PIP Aim Statement**			6	4	66.7%
	2.1	The PIP aim statement clearly specified the improvement strategy for the PIP.	**0**			
	2.2	The PIP aim statement clearly specified the population for the PIP.	**0**			
	2.3	The PIP aim statement clearly specified the time period for the PIP.	**1**			
	2.4	The PIP aim statement was concise.	**1**			

	2.5	The PIP aim statement was answerable.	**1**			
	2.6	The PIP aim statement was measurable.	**1**			
3	**PIP Population**			2	2	100.0%
	3.1	The project population was clearly defined in terms of the identified PIP question.	**1**			
	3.2	If the entire MCO population was included in the PIP, the data collection approach captured all enrollees to whom the PIP question applied.	**1**			
4	**Sampling Method**			5	5	100.0%
	4.1	The sampling frame contained a complete, recent, and accurate list of the target PIP population. (The sampling frame is the list from which the sample is drawn.)	**1**			
	4.2	The sampling method considered and specified the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error.	**1**			
	4.3	The sample contained a sufficient number of enrollees taking into account non-response.	**1**			
	4.4	The method assessed the representativeness of the sample according to subgroups, such as those defined by age, geographic location, or health status.	**1**			
	4.5	Valid sampling techniques were used to protect against bias.	**1**			
5	**PIP Variables and Performance Measures**			9	7	77.8%
	5.1	The variables were adequate to answer the PIP question.	**1**			
	5.2	The performance measure assessed an important aspect of care that will make a difference to enrollees' health or functional status.	**0**			

	5.3	The performance measures were appropriate based on the availability of data and resources to collect the data.	**1**			
	5.4	The measures were based on current clinical knowledge or health services research.	**0**			
	5.5	The performance measures monitored, tracked, and compared performance over time; and informed the selection and evaluation of quality improvement activities.	**1**			
	5.6	The MCO considered existing measures such as CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, or AHRQ measures.	**0**			
	5.7	The MCO developed new measures based on current clinical practice guidelines or health services research if there were gaps in existing measures.	**1**			
	5.8	The measures captured changes in enrollee satisfaction or experience of care.	**1**			
	5.9	The measures included a strategy to ensure inter-rater reliability (if applicable).	**1**			
	5.10	The process measure is meaningfully associated with outcomes (if applicable).	**1**			
6	**Data Collection Procedures**			17	17	100.0%
	General					
	6.1	The PIP design specified a systematic method for collecting valid and reliable data that represents the population in the PIP.	**1**			
	6.2	The PIP design specified the frequency of data collection.	**1**			
	6.3	The PIP design clearly specified the data sources.	**1**			

6.4	The PIP design clearly defined the data elements to be collected.	**1**	
6.5	A list of data collection personnel and their relevant qualifications was provided.	**1**	
6.6	The data collection plan linked to the data analysis plan to ensure that appropriate data would be available for the PIP.	**1**	
6.7	The data collection instruments allowed for consistent and accurate data collection over the time periods studied.	**1**	
6.8	Qualitative data collection methods were well-defined and designed to collect meaningful and useful information from respondents (if applicable).	**1**	
Administrative Data Sources (if applicable)			
6.9	If inpatient data was used, the data system captured all inpatient admissions/discharges.	**1**	
6.10	If primary care data was used, primary care providers submitted encounter or utilization data for all encounters.	**1**	
6.11	If specialty care data was used, specialty care providers submitted encounter or utilization data for all encounters.	**1**	
6.12	If ancillary data was used, ancillary service providers submitted encounter or utilization data for all services provided.	**1**	
6.13	If LTSS data was used, all relevant LTSS provider services were included.	**1**	
6.14	If EHR data was used, patient, clinical, service, or quality metrics were validated for accuracy and completeness as well as comparability across systems.	**1**	
Medical Record Review (if applicable)			
6.15	A list of data collection personnel and their relevant qualifications was provided.	**1**	

	6.16	For medical record review, interrater and intra-rater reliability was described.	**1**			
	6.17	For medical record review, guidelines for obtaining and recording the data were developed.	**1**			
7	**Data Analysis and Interpretation of PIP Results**		**0**	8	4	50.0%
	7.1	The analysis was conducted in accordance with the data analysis plan.	**0**			
	7.2	The analysis included baseline and repeat measurements of project outcomes.	**0**			
	7.3	The analysis assessed the statistical significance of any differences between the initial and repeat measurements.	**0**			
	7.4	The analysis accounted for factors that may influence the comparability of initial and repeat measurements.	**0**			
	7.5	The analysis accounted for factors that may threaten the internal or external validity of the findings.	**1**			
	7.6	The PIP compared the results across multiple entities, such as different patient subgroups, provider sites, or MCOs.	**1**			
	7.7	PIP results and findings were presented in a concise and easily understood manner.	**1**			
	7.8	To foster continuous quality improvement, the analysis and interpretation of the PIP data included lessons learned about less-than-optimal performance.	**1**			
8	**Improvement Strategies**			6	0	0.0%
	8.1	The selected improvement strategy was evidence-based, that is, there was existing evidence (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables).	**0**			

	8.2	The strategy was designed to address root causes or barriers identified through data analysis and quality improvement processes.	**0**			
	8.3	The rapid-cycle PDSA approach was used to test the selected improvement strategy.	**0**			
	8.4	The strategy was culturally and linguistically appropriate.	**0**			
	8.5	The implementation of the strategy was designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices).	**0**			
	8.6	Building on the findings from the data analysis and interpretation of PIP results, the PIP assessed the extent to which the improvement strategy was successful and identify potential follow-up activities.	**0**			
9	Significant and Sustained Improvement			5	5	100.0%
	9.1	The same methodology was used for baseline and repeat measurements.	**1**			
	9.2	There was quantitative evidence of improvement in processes or outcomes of care.	**1**			
	9.3	The reported improvement in performance was likely to be a result of the selected intervention.	**1**			
	9.4	There is statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention.	**1**			
	9.5	Sustained improvement was demonstrated through repeated measurements over time.	**1**			

Total Possible Points (all standards)	Total Points Received	Overall Validity & Reliability Percentage
63	49	77.8%

90% - 100%	High Confidence
80% - 89.9%	Moderate Confidence
70% - 79.9%	Low Confidence
<70%	No Confidence

Overall Validity & Reliability Rating: Low Confidence

Appendix J: PIP Template

Performance Improvement Project (PIP)

Proposal and Final Report Format Template

Instructions:

- Reference the PIP section of the Quality Guide for additional information.
- PIP Proposal: Complete standards 1-6 and 8 in this template.
- Final PIP Report Validation: Complete standards 7 and 9 in this template. Make any updates to standards 1-6 and 8 if changes were made after the proposal was approved, including changes made as a result or EQRO recommendations or changes made to facilitate project implementation.

HMO Name: Click here to enter text.	**Report Prepared by:** Click here to enter text.
Date Proposal Submitted: Click here to enter a date.	**Date Final Report Submitted:** Click here to enter a date.
Project Title: Click here to enter text.	
Project Implementation Date: Click here to enter a date.	
Please check the following items as applicable to this PIP report	
PIP Proposal Type: ☐ Clinical ☐ Nonclinical	
Population: ☐ SSI ☐ BC+ ☐ Both SSI and BC+	
Primary HMO Contact Regarding PIP Project Click or tap here to enter text.	
Email: Click or tap here to enter text.	**Phone:** Click or tap here to enter text.
HMO Project Team	
Name	**Title/Department**
STANDARD 1: PIP Topic ***Standard 1 applies to PROPOSAL and VALIDATION*** 1.1 The PIP topic was selected through a comprehensive analysis of HMO member needs, care and services.	

1.2 The PIP topic considered performance on the CMS Child and Adult Core Set measures (if applicable).
1.3 The selection of the PIP topic considered input from members or providers who are users or concerned with specific service areas.
1.4 The PIP topic addresses care of special populations or high priority services.
1.5 The PIP topic aligns with priority areas identified by DHS and/or CMS.

1a. Describe the process or analysis used to prioritize and select this topic as an area or opportunity for improvement related to **reducing health inequities**. HMOs must consider stratification of any or all target populations by rural/urban, sex, age, primary language, race, and/or ethnicity (encouraged to select at least two stratifications) in order to identify health equity quality improvement opportunities.

Information should include:

- Discussion of the member needs assessment or source data that helped identify baseline performance
- Baseline data and the timeframe of the baseline data
- Address any performance measures considered in the selection of the topic

1b. Describe the relevance of this topic to the HMO's membership

- Identify how the topic relates to the member health status and/or member experience. Address consideration of health inequities, care of special populations, and/or high priority services as applicable
- Identify why the topic is important to members, giving consideration to members' social determinants of health.

1c. Describe any member and provider input obtained in considering this topic.

Standard 1 PIP Topic:

Click or tap here to enter text.

STANDARD 2: PIP Aim Statement

Standard 2 applies to PROPOSAL and VALIDATION

2.1 The PIP aim statement clearly specifies the improvement strategy *(relevant to Standards 8.1 -8.4)*
2.2 The PIP aim statement clearly specifies the population for the PIP
2.3 The PIP aim statement clearly specifies the time period for the PIP
2.4 The PIP aim statement is concise
2.5 The PIP aim statement is answerable
2.6 The PIP aim statement is measurable

2a. State each PIP aim or question in a concise, answerable, and measurable format, including:

- Specific numerical goal(s) and target date(s)
- Intervention or improvement strategy that will be implemented
- Rate of desired improvement (from what to what) in each aim or question
- Population that will be involved in the PIP

Standard 2 PIP Aim Statement:

Click or tap here to enter text.

STANDARD 3: PIP Population

Standard 3 applies to PROPOSAL and VALIDATION

3.1 The project population is clearly defined in terms of the identified PIP question

3.2 If the entire HMO population is included in the PIP, the data collection approach captures all members to whom the PIP aim or question applies

3a. Describe the relevant population (all members to whom the study question and indicators apply), including:

- Target populations by rural/urban, race, ethnicity, sex, gender, age, primary language, disability, etc.
- Any inclusion or exclusion criteria
- Any enrollment/eligibility criteria (e.g., requirements for how long members had to be enrolled)

3b. If data for the entire HMO population will be studied, describe how the data collection approach will capture all members to whom the study question applied

Standard 3 PIP Population:

Click or tap here to enter text.

STANDARD 4: Sampling Method

Standard 4 applies to PROPOSAL and VALIDATION

4.1 The sampling frame contains a complete, recent, and accurate list of the target PIP population.

4.2 The sampling method considers and specifies the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error

4.3 The sample contains a sufficient number of members taking into account non-response

4.4 The method assesses the representativeness of the sample according to subgroups, such as those defined by age, geographic location, or health status

4.5 Valid sampling techniques were used to protect against bias

4a. If sampling will be utilized (i.e., data for a sample of the population will be studied and findings generalized to the entire population), provide a detailed explanation of the sampling methods to be used (e.g., sample size/population size, sampling technique used, confidence intervals, acceptable margin of error).

If 4a. is not applicable to this project, enter "N/A" here

Standard 4 Sampling Method:

Click or tap here to enter text.

STANDARD 5: PIP Variables and Performance Measures

Standard 5 applies to PROPOSAL and VALIDATION

5.1 The variables are adequate to answer the PIP question
5.2 The performance measures assess an important aspect of care that will make a difference to members' health or functional status
5.3 The performance measures are appropriate based on the availability of data and resources to collect the data
5.4 The measures are based on current clinical knowledge or health services research
5.5 The performance measures will monitor, track, and compare performance over time; and inform the selection and evaluation of quality improvement activities
5.6 The HMO considered existing measures such as CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, or AHRQ measures
5.7 The HMO developed new measures based on current clinical practice guidelines or health services research if there were gaps in existing measures
5.8 The measures captured changes in member satisfaction or experience of care
5.9 The measures include a strategy to ensure inter-rater reliability (if applicable)
5.10 The process measure is meaningfully associated with outcomes (if applicable)

5a. List and define all study indicators/performance measures.
- Clearly define each numerator and denominator
- Ensure the indicators are concise, measurable, and adequately answer the PIP aim(s) or questions(s)

5b. Briefly summarize how the performance measure(s):
- Assess an important aspect of care that will make a difference to members' health or experience
- Are appropriate based on the availability of data and resources to collect the data
- Are based on current clinical knowledge or health services research
- Will monitor, track, and compare performance over time and inform the selection and evaluation of quality improvement activities
- Address any gaps in existing measures, if applicable

5c. If CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, AHRQ or other existing measures are used, include the relevant specifications

Standard 5 PIP Variables and Performance Measures:

Click or tap here to enter text.

STANDARD 6. Data Collection Procedures

Standard 6 applies to PROPOSAL and VALIDATION

6.1 The PIP design specifies a systematic method for collecting valid and reliable data that represents the population in the PIP
6.2 The PIP design specifies the frequency of data collection
6.3 The PIP design clearly specifies the data sources
6.4 The PIP design clearly defines the data elements to be collected

6.5 The data collection plan links to the data analysis plan to ensure that appropriate data would be available for the PIP
6.6 The data collection instruments will allow for consistent and accurate data collection over the time periods studied
6.7 Qualitative data collection methods are well-defined and designed to collect meaningful and useful information from respondents (if applicable)

Administrative Data Sources (if applicable)
6.8 If inpatient data will be used, the data system captures all inpatient admissions/discharges
6.9 If primary care data will be used, primary care providers submit encounter or utilization data for all encounters
6.10 If specialty care data will be used, specialty care providers submit encounter or utilization data for all encounters
6.11 If ancillary data will be used, ancillary service providers submit encounter or utilization data for all services provided
6.12 If LTSS data will be used, all relevant LTSS provider services are included
6.13 If EHR data will be used, patient, clinical, service, or quality metrics are validated for accuracy and completeness as well as comparability across systems

Medical Record Review (if applicable)
6.14 A list of data collection personnel and their relevant qualifications is provided
6.15 For medical record review, interrater and intra-rater reliability is described
6.16 For medical record review, guidelines for obtaining and recording the data were developed

Study results are dependent on accurate and valid data that are collected appropriately. Clearly describe the data collection components for all PIP indicators.
6a. Identify all data sources (e.g., claims/administrative data, member files)
6b. Describe how data was collected
6c. Provide a list of data collection personnel and their relevant qualifications
6d. Describe how the data was stored and aggregated (e.g., registry, database)
6e. Describe how the data was analyzed and by whom
6f. Describe the frequency of data collection and analysis

For continuing projects, include the data from the previous year(s) in addition to any data from the current year. Include samples of any data collection tools or instruments as an attachment.

Standard 6 Data Collection Procedures:
Click or tap here to enter text.

STANDARD 7. Data Analysis and Interpretation of PIP Results
Standard 7 applies to VALIDATION. HMOs do not need to address this in the PIP Proposal.
7.1 The analysis was conducted in accordance with the data analysis plan.
7.2 The analysis included baseline and repeat measurements of project outcomes.

7.3 The analysis assessed the statistical significance of any differences between the initial and repeat measurements
7.4 The analysis accounted for factors that may influence the comparability of initial and repeat measurements
7.5 The analysis accounted for factors that may threaten the internal or external validity of the findings
7.6 The PIP compared the results across multiple entities, such as different patient subgroups, provider sites, or HMOs
7.7 PIP results and findings were presented in a concise and easily understood manner
7.8 To foster continuous quality improvement, the analysis and interpretation of the PIP data included lessons learned about less-than-optimal performance

In a concise and easily understood manner:
7a. Describe how the data analysis was conducted and aligned with the data analysis plan
7b. Identify the baseline and repeat measurements of the project outcomes
7c. Identify the statistical significance of any differences between the initial and repeat measurements and account for any factors that may influence the comparability of initial and repeat measurements
7d. Discuss any factors that may threaten the internal or external validity of the findings
7e. As applicable, discuss comparison of the results across multiple entities, such as different member subgroups, provider sites, or HMOs
7f. Identify and discuss any lessons learned about less-than-optimal performance

- Include baseline, interim data, and repeat measurement(s)
    - Was the same methodology used for the baseline and repeat measurements? (Note Standard 9.1)
    - Are the numerical results accurate and clear?
- Effectiveness and/or accuracy of the numerators and denominators used in data analysis
- Discussion of ongoing data review in accordance with the data analysis plan.
- Include any tables, charts, and/or graphs as applicable

For continuing projects, include any data and analysis from both the current year and previous year(s).

Standard 7 Data Analysis and Interpretation of PIP Results:
Click or tap here to enter text.

STANDARD 8. Improvement Strategies
Standard 8 applies to PROPOSAL and VALIDATION
8.1 The selected improvement strategy was evidence-based, that is, there was existing evidence (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables)

8.2 The strategy was designed to address root causes or barriers identified through data analysis and quality improvement processes 8.3 The rapid-cycle PDSA approach was used to test the selected improvement strategy. 8.4 The strategy was culturally and linguistically appropriate 8.5 The implementation of the strategy was designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., member risk factors, Medicaid program changes, provider education, clinic policies or practices) 8.6 Building on the findings from the data analysis and interpretation of PIP results, the PIP assessed the extent to which the improvement strategy was successful and identify potential follow-up activities
8a. Describe how the improvement strategy was selected with respect to available evidence from the literature, data, root cause analysis, or barrier analysis 8b. Explain how the improvement strategy was determined to be likely to lead to the desired improvement in processes or outcomes 8c. Discuss how the improvement strategy was designed to address root causes or barriers identified through data analysis and quality improvement processes, including how the Plan-Do-Study-Act (PDSA) approach was utilized 8d. Discuss how the improvement strategy was culturally and linguistically appropriate 8e. Describe how implementation of the strategy was designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., member risk factors, Medicaid program changes, provider education, clinic policies or practices) 8f. With respect to the PIP data analysis and interpretation of the results, explain how the PIP assessed the extent to which the improvement strategy was successful; identify potential follow-up activities (note Standard 9.2 and 9.3) Include any materials that were developed and/or used for interventions, such as, member educational materials, practice guidelines, etc., as attachments to this report. For continuing projects, provide documentation that focuses on interventions implemented during the current project period.
Standard 8 Improvement Strategies: Click or tap here to enter text.
STANDARD 9. Significant and Sustained Improvement ***Standard 9 applies to VALIDATION. HMOs do not need to address this in the PIP Proposal.*** 9.1 The same methodology was used for baseline and repeat measurements. 9.2 There was quantitative evidence of improvement in processes or outcomes of care. 9.3 The reported improvement in performance was likely to be a result of the selected intervention. 9.4 There is statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention. 9.5 Sustained improvement was demonstrated through repeated measurements over time.
9a. Clearly describe how the same methodology was used for baseline and repeat measurements

9b. Specify the quantitative evidence of improvement in processes or outcomes of care 9c. Discuss the extent to which reported improvement in performance was likely to be a result of the selected intervention(s), including any statistical evidence 9d. If applicable, identify any sustained improvement demonstrated through repeated measurements over time For continuing projects, include the relevant data from previous year(s) and any analysis of the data from the current year to previous year(s).
Standard 9 Significant and Sustained Improvement: Click or tap here to enter text.

In the space below:

- **Please list any references relevant to this PIP final report.**
- **Attach any relevant documents (or include attachments in the report submission packet)**

Click or tap here to enter text.

Appendix K: NCQA Accreditation Policy Memo

Tony Evers
Governor

Karen E. Timberlake
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF MEDICAID SERVICES
1 WEST WILSON STREET
PO BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
Fax: 608-266-1096
TTY: 711

Date: March 26, 2021
To: BadgerCare Plus and Medicaid SSI HMO CEOs & Contract Administrators
From: Jim Jones, Administrator, Division of Medicaid Services

Final Update

This memo reflects the final policy decisions of the Department as it relates to the NCQA Health Plan Accreditation and NCQA Multicultural Health Care Distinction requirements. In response to the most recent feedback from health plans, **we have made the July 2022 Interim NCQA Accreditation an optional milestone (see page 9)**. The deadlines for Full NCQA Health Plan Accreditation and the Multicultural Health Care Distinction remain December 31, 2023.

Multiple health plans have asked for clarification on quarterly progress reporting guidelines and we have provided those clarifications on page 9 of this memo. A quarterly reporting template has been sent to the contract administrators via email with completion instructions and due dates. The first update will be due July 1, 2021. Any questions regarding the quarterly progress updates should be directed to your assigned DMS analyst.

Policy regarding the implementation milestones and reporting requirements will be incorporated into the 2022-2023 BadgerCare Plus and Medicaid SSI HMO Contract. This contract language will be shared with as part of the 2022 contract renewal process led by DMS's Bureau of Programs and Policy (BPP). BPP shared the timeline for this year's contract renewal process at the February Contract Administrator's meeting. At this time, it is expected that HMOs will receive all proposed contract changes on August 2nd, 2021.

Thank you for your continued engagement in this project and other DMS Managed Care initiatives. If you have any further comments please reach out to your assigned DMS analyst. If you prefer to meet in person you are also welcome to reach out to Gina Anderson, Gina.Anderson@dhs.wisconsin.gov, to set up a time to meet.

1

Project Background

In 2020 DMS identified three priority initiatives to improve the managed care programs offered by Wisconsin Medicaid:

1. Improve the quality and oversight of acute and primary Medicaid HMOs
2. Maximize Medicare use by members who are enrolled in both Medicaid and Medicare (dual eligibles)
3. Improve health equity, especially in addressing racial health disparities

The goal of these initiatives is to create a seamless managed care service delivery system, , which provides health care that is equitable, person-centered, culturally competent and simple to understand and navigate.

The NCQA accreditation requirement exploration falls under *the first initiative to Improve Quality and Oversight of HMOs*. This memo details: 1) a brief comparison of national accreditors; 2) an overview of the NCQA accreditation process and the various accreditation options offered; and 3) the proposed timeline for implementation.

DMS Findings from Comparison of Major National Accreditors

This overview focuses on three major national accrediting bodies: the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), and the Accreditation Association for Ambulatory Health Care (AAAHC). California recently partnered with Health Management Associates to provide an analysis of these three accreditors to determine the best fit for the state's Marketplace issuers.[1] While Wisconsin is interested in accreditation for Medicaid health plans, not Marketplace, the California report is still useful as it examines key areas of interest, such as accreditation structure, content and process, market reach, and accreditation methodology.

Based on the results of the California analysis, internal discussions at DMS, and a desire to align with other state Medicaid agencies, ***DMS will use NCQA as the required accreditor for BadgerCare Plus and Medicaid SSI health plans***. The justification for this decision is detailed below.

Why Choose a Single Accrediting Body?

It is possible for Wisconsin to simply require accreditation by any national or CMS-recognized accreditor, however, this approach has significant drawbacks.

First and foremost, while this approach provides more flexibility, it would significantly increase oversight and administrative burden on DMS staff. Utilization of multiple accrediting bodies would require much more effort when determining the deeming crosswalk[2] for non-duplication of external quality review activities. Essentially, the state would need to determine the overlap of accreditation review activities with external quality review activities for each allowed

[1] *National Accreditation Bodies and Fit for Covered California*. Prepared for Covered California by Health Management Associates, September 2020

[2] Deeming is a process by which the state may use information from private accreditation review of a health plan to provide information for the annual external quality review (EQR). The crosswalk is required by CMS as part of our Medicaid managed care quality strategy.

accreditation type. This is a very complex and time consuming process that would become much more difficult as more accreditation types are added to the crosswalk.

Second, it inhibits DMS's ability to incorporate specific accreditation standards into contract and oversight requirements. For example, Tennessee requires that many of the reports and documentation submitted to the state meet NCQA standards and/or allows NCQA analysis to be submitted to the state to fulfill contractual requirements. Tennessee Medicaid references NCQA standards and benchmarks over 300 times in its contractual requirements.[3]

Finally, utilization of multiple accrediting bodies would lead to less consistency across health plans within the state. While all of the major accrediting bodies cover basic regulatory requirements in their review, there is moderate variation between the accreditors in both content reviewed and the level of rigor required for accreditation. This may not lead to excessive variation in the core functions of Wisconsin Medicaid health plans, but the fact remains that different standards would be present throughout the state.

Given the drawbacks outlined above, ***DMS will use a single accrediting body for health plan accreditation.*** This will reduce administrative burden for the state and promote consistency across health plans.

Content of Accreditation Review

The three accrediting bodies reviewed for this briefing (NCQA, URAC, and AAAHC) have significant overlap in their required reviews for regulatory compliance and standards of quality. However, NCQA stands out in two key areas: assessment of core health plan functions and documentation/data requirements.

All three accreditors evaluate standards for core functions including, but not limited to, quality management and improvement, continuity and coordination of care, provider network management, utilization management, and member experience. However, NCQA provides the most comprehensive review of these functions, requiring review of a higher number of core elements in the areas of utilization management, disease management, and grievances and appeals.[4]

Furthermore, NCQA requires more rigorous documentation for the required elements for accreditation. While URAC and AAAHC technically review a greater number of elements than NCQA, the majority of these elements only require process documentation and review of materials such as member newsletters and notifications. In contrast, 60 percent of NCQA required elements require reports to verify adherence to standards (in addition to process documentation and materials).[5]

Finally, NCQA requires submission of both HEDIS and CAHPS results as part of the health plan accreditation process. While a health plan's HEDIS and CAHPS performance will not influence whether or not they are accredited, submission is mandatory and all accredited health plans are ranked on a scale of 1 to 5.

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[3] https://www.tn.gov/content/dam/tn/tenncare/documents2/vshp.pdf

[4] *National Accreditation Bodies and Fit for Covered California.* Prepared for Covered California by Health Management Associates, September 2020.

[5] Ibid

Additional Benefits of NCQA Accreditation

In addition to more rigorous content review and better coverage of core health plan activities, NCQA has by far the most market reach. NCQA has 712 accreditations nationally, while URAC has 39, and AAAHC has only 32.[6] Additionally, as of September 2020, 31 states required NCQA accreditation for Medicaid health plans, with at least 12 leveraging the deeming process to reduce oversight burden. Furthermore, the current Wisconsin HMO Quality Strategy and pay-for-performance program is tied to HEDIS measures, which are also developed and managed by NCQA.

NCQA Accreditation

Based on the strengths outlined above, DMS will use NCQA as the required accreditor for BadgerCare Plus and Medicaid SSI HMOs. Utilizing NCQA for health plan accreditation allows the state to leverage the resources and experience offered by the industry leader in accreditation, while also providing a level of familiarity and consistency to health plans.

Overview of NCQA Accreditation Process and Options

NCQA offers a number of different accreditation and certification programs for both individuals and organizations, all of which focus on providing a framework for improving operations and aligning with health care industry best practice. Certain programs offered by NCQA also provide a framework for health plans to achieve and maintain compliance with state and federal regulations. As Wisconsin is exploring NCQA accreditation for its BadgerCare Plus and Medicaid SSI HMOs, any discussion of "NCQA accreditation" is referring to NCQA's Health Plan Accreditation program and related modules and certifications.

Based on the options for NCQA accreditation, the different paths to accreditation offered by NCQA, and the timeline for implementation, ***DMS will require NCQA Accreditation in Medicaid lines of business and the Multicultural Health Care distinction for BadgerCare Plus and Medicaid SSI health plans.***

NCQA Accreditation Options: Lines of Business

When applying for NCQA accreditation, health plans must identify the products and product lines it is seeking accreditation for. Products that are eligible for NCQA accreditation include health maintenance organizations (HMOs), point-of-service-plan (POS), preferred provider organizations (PPOs) and exclusive provider organizations (EPOs). The different product lines NCQA offers accreditation in are commercial, Medicaid, Medicare, and Exchange (ACA Marketplace) lines of business.

It is important to note that seeking accreditation in Medicaid, Medicare, or Exchange lines of business does not require additional fees or a different application process. When conducting the

[6] *National Accreditation Bodies and Fit for Covered California*. Prepared for Covered California by Health Management Associates, September 2020.

accreditation review, NCQA applies universal standards to all health plans including functional areas such as Population Health Management and Network Management.[7,8]

As DMS will be requiring NCQA accreditation for BadgerCare Plus and Medicaid SSI health plans, it makes the most sense to require health plan accreditation specifically in Medicaid lines of business. The element groups reviewed for Medicaid lines of business ensure that Medicaid accredited health plans are adhering to federal Medicaid regulations.

A second benefit of requiring Medicaid accreditation is that HEDIS and CAHPS submissions – and by extension the NCQA star ratings – would be specific to Medicaid members. While NCQA accredited plans are already administering CAHPS surveys, the population surveyed corresponds to the line of business the health plan is accredited in (e.g. Commercial only). By requiring Medicaid accreditation, DMS can be sure that any star ratings assigned to health plans by NCQA are reflective of the quality of care and customer service provided to Wisconsin Medicaid beneficiaries. Additionally, DHS currently administers CAHPS only for a sample of fee-for-service and BadgerCare Plus children. If all health plans were NCQA Medicaid accredited, the health plan administered CAHPS results could be a useful source of data for DMS about member satisfaction and feedback, particularly for populations that DHS does not currently survey (e.g. BC+ Adults).

NCQA Accreditation Options: Modules and Distinctions

In addition to the base accreditation program, NCQA also offers additional modules and "distinction" programs as add-on options for accredited health plans. Two such programs that may be of particular interest to DMS are the NCQA Health Plan Medicaid Module and the Multicultural Health Care Distinction program.

The NCQA Medicaid Module is an optional program that is only available to Medicaid accredited health plans. The Medicaid Module provides a slightly more rigorous review of Medicaid standards when compared to the base Medicaid health plan accreditation. The primary goal of the program is to provide a more comprehensive "deeming" plan, thereby reducing oversight burden on both health plans and state oversight staff. However, according to NCQA, "The NCQA [Health Plan Surveys] cover most requirements in an organization's NCQA Health Plan-Medicaid Module Survey."[9] Taking this into account, along with the additional $9,500 fee, ***the Medicaid Module likely does not provide enough added value to pursue at this time***. However, the enhanced deeming provided by the Medicaid Module may prove useful in future years. DMS will evaluate the Medicaid Module as a possible future requirement as we work through updating and evaluating the deeming process.

The NCQA Multicultural Health Care (MHC) distinction is another optional program that is available to health plans, wellness and population health groups, and other organizations. The MHC distinction focuses on ensuring organizations provide culturally and linguistically appropriate services (CLAS) and are actively working to reduce health care disparities. In

[7] *2020 Standards and Guidelines for the Accreditation of Health Plans*. NCQA, 2019

[8] CORRECTION: In the previous version of this memo it was stated that the base NCQA review included 15 additional element groups for Medicaid accreditation. After discussions with NCQA we identified that this was an error. The 15 additional element groups that were referenced are actually part of the NCQA Medicaid Module, an optional add-on module similar to the MHC distinction.

[9] *2020 Standards and Guidelines for the Accreditation of Health Plans*. NCQA, 2019, p. 56

contrast to the Medicaid Module, it does appear that the MHC distinction provides significant added value over the base health plan accreditation review, which may explain why two BadgerCare Plus and Medicaid SSI health plans have already elected to pay for the program. The MHC distinction evaluates an organization's compliance on the following CLAS standards:

- Collecting race/ethnicity and language data
- Providing language assistance
- Cultural responsiveness
- Quality improvement of CLAS
- Reduction of health care disparities

This review goes much further than the base health plan accreditation review, which only evaluates two elements relating to cultural and linguistic needs for members: 1) availability of appropriate practitioners within the network, and 2) the provision of culturally competent services to Medicaid members.

DMS will require that health plans achieve the MHC distinction, as it aligns with DHS priorities and the current HMO Quality Strategy and will ensure all health plans are subjected to a comprehensive review of CLAS standards.

NCQA Accreditation Options: Type of Survey

NCQA offers three different types of accreditation review, which are also referred to as evaluation surveys. The type of evaluation survey best suited to a health plan depends on their current NCQA accreditation status and level of preparedness for the accreditation review. Health plans that have never been accredited by NCQA are encouraged to pursue an "Interim Evaluation", which is an abbreviated version of the full NCQA review. With an Interim Evaluation, health plans can achieve NCQA accreditation status faster and are not required to submit HEDIS/CAHPS data until the calendar year following their initial accreditation. Interim Accreditation status can last up to 18 months, at which time the health plan will be required to complete a full review, which is referred to as a "First Evaluation" by NCQA. The First Evaluation includes a full accreditation review and applies to health plans who are not currently accredited with NCQA. Finally, the "Renewal Evaluation" is a full accreditation review that applies only to health plans that are currently accredited with NCQA. Both the First Evaluations and Renewal Evaluations lead to full health plan accreditation and can last up to three years. After three years, the health plan will need to re-apply for accreditation with NCQA.

DMS will require only the base NCQA Health Plan Accreditation within health plan's Medicaid lines of businesses for initial rollout of the requirement. While the NCQA accreditation process can take up to 3 years to successfully complete, the majority of Wisconsin BC+ and SSI health plans are already NCQA accredited in at least one line of business. Because of this, most health plans should already be close to alignment with NCQA requirements, dramatically reducing the length of preparation time needed to achieve accreditation. Additionally, health plans applying for the first time could utilize the Interim Accreditation glide path to further reduce the amount of preparation needed to achieve initial NCQA accreditation.

Accreditation Costs and Current NCQA Accreditation Status for Wisconsin Health Plans

Health plans that have not been accredited by NCQA in any of their lines of business would face the highest costs to achieve NCQA accreditation. Based on cost breakouts provided to DMS by

an NCQA representative, the four Wisconsin Medicaid health plans without NCQA accreditation (see table 1 below) would face an average cost of roughly $80,000 their initial accreditation review cycle. This higher cost is due to the cost of the initial Interim Evaluation, followed by the full First Evaluation shortly after. The $80,000 dollars would be spread over a maximum time period of 54 months – 18 months maximum for Interim Accreditation and the standard 36 month cycle for Full Accreditation.

For renewing health plans and plans that are accredited in other product lines, the cost is much lower. This is because a plan does not need to pay the base accreditation fee for every product they are accredited for. So a plan that is accredited in commercial and Medicaid lines of business would only need to pay for the base fee once, plus the additional member fee for each covered life.

The Department has reviewed initial cost estimates for NCQA accreditation and has not found them to be material in nature. That said, as with all contractual requirements, cost will be assessed going forward to ensure capitation rates are actuarially sound.

Table 1 below provides the current NCQA accreditation status for Wisconsin BadgerCare Plus and Medicaid SSI health plans across commercial, Medicaid, and Medicare lines of business.[10] At this time, 11 of the 15 health plans are NCQA accredited in at least one of their lines of business, with 6 accredited in their Medicaid line of business.

Table 1: NCQA Accreditation Status for BadgerCare Plus and Medicaid SSI HMOs

Plan	Medicaid	Commercial	Medicare	Exchange	Distinctions
Anthem BCBS	X	X			Multicultural Health Care
Care WI					
CCHP	X	X		X	
Dean		X		X	
GHC-EC					
GHC-SCW		X		X	
iCare					
MHS	X				
NHP		X		X	
MercyCare		X		X	
Molina	X			X	Multicultural Health Care
Quartz		X	X	X	

[10] Based on NCQA Report Card Data. Last Updated 9/14/2020. https://reportcards.ncqa.org/#/health-plans/list?state=Wisconsin

Security	X	X	X	X	
Trilogy					
UHC	X	X	X	X	

Implementation Timeline

DMS plans to utilize the HMO Contract and Certification Process to ensure statewide adoption of NCQA accreditation. ***DMS will require that each plan meets these deadlines for implementation of NCQA accreditation:***

- Health plans must achieve full NCQA accreditation in Medicaid lines of business by end of calendar year 2023 (December 31, 2023).
- **Health plans not currently NCQA accredited may choose to achieve interim NCQA accreditation in Medicaid lines of business as part of an optional glide path to full accreditation.**
- Health plans must achieve the NCQA Multicultural Healthcare Distinction by the end of calendar year 2023 (December 31, 2023).

As it stands, 11 of the 15 BadgerCare Plus and Medicaid SSI HMOs are NCQA accredited in at least one line of business, and six are already Medicaid accredited. For these health plans, we expect that obtaining NCQA accreditation in Medicaid lines of business will be relatively straightforward. We hope that the updated implementation timeline will provide additional flexibility for health plans attempting to align NCQA accreditation reviews across multiple lines of business.

For health plans that are not NCQA accredited in any lines of business, the implementation deadline should provide ample time to achieve accreditation. The December 2023 deadline gives health plans two years and nine months to conduct gap analyses to come into full compliance with NCQA standards. Furthermore, the optional interim accreditation pathway requires only a limited review by NCQA, allowing plans that are not currently accredited to quickly come into compliance on core review standards and setting up a glide path to full accreditation. Achieving interim accreditation is recommended, as it will allow health plans to take advantage of the deeming process and will provide an opportunity to become familiar with the NCQA review process to prepare for full accreditation. Additionally, achieving interim accreditation will allow health plans to be considered NCQA Accredited on public-facing DHS materials.

Contract language will be developed by DMS for incorporation into the 2022 BadgerCare Plus and Medicaid SSI HMO Contract. The contract language will require HMOs to demonstrate progress towards compliance milestones outlined above. The contract language will be shared as part of the contract renewal process led by DMS's Bureau of Programs and Policy (BPP). At this time, it is expected that HMOs will receive all proposed contract changes on August 2nd, 2021.

In an effort to ensure a smooth implementation, DMS will continue to monitor the following issues raised by health plans:

- NCQA review schedules. Specifically, how reviews align across lines of business and whether any adjustments need to be made to the timeline.
- Whether or not a financial incentive or other reimbursement is warranted.
- Unforeseen barriers that arise that may jeopardize the implementation timeline for health plans.

To facilitate this ongoing evaluation and monitor implementation progress, we will be asking health plans to provide written quarterly updates to DMS. These quarterly updates will include an initial work plan outlining how the health plan will achieve the requirements outlined above, followed by report-outs on progress towards implementation. The first quarterly progress reports will be due on July 1st, 2021. A quarterly progress reporting template has been shared with HMO contract administrators and includes the following reporting requirements:

- Submission of initial implementation workplan
- Project Status
- NCQA contacted
- NCQA Accreditation review scheduled
- MCHD review scheduled
- NCQA requirement gap analysis conducted
- Narrative submission detailing how the health plan will mitigate shortcomings from gap analysis
- Ongoing status of mitigation tasks

Health plans are encouraged to include any information that may be useful in DMS's evaluation of the above concerns, particularly any unforeseen barriers that may jeopardize implementation timelines.

Health plans not making satisfactory progress towards achieving implementation deadlines may be subject to corrective actions, as detailed in the HMO contract. Instances where corrective actions may be applied include but are not limited to: consistently failing to meet workplan deadlines, project status being indicated as off-track by the health plan, and failure to schedule NCQA reviews within acceptable timeframes. BQO and BPP staff will be in regular communication with health plans regarding their implementation progress and ample opportunity will be provided for health plans to avoid corrective actions.

Process for Failure to Meet Requirements

Under this proposal, DMS review of NCQA accreditation compliance would occur in June of 2023. At this time, DMS would determine whether or not a health plan is expected to meet the accreditation requirements by the end of December 2023. This determination will be made based on the information provided in quarterly updates and one-on-one discussions with each health plan to determine their readiness for NCQA review. Health plans that are not expected to meet the December 2023 implementation deadline would not be offered a new contract due to a failure to meet contractual obligations and certification requirements.

Please note that health plans with NCQA review dates after June 2023 and before December 2023 would not be denied a new contract if it is determined they are likely to meet the implementation deadlines.

Following the June 2023 review, health plans that are not expected to meet the implementation deadlines will be subject to the following actions:

1. Health plan will be required to develop a transition plan in coordination with DMS.
2. New member enrollments into the HMO will stop.
3. 6-month period to transfer current members to a new health plan.

Resources

URAC Accreditation and Certification Programs - https://www.urac.org/accreditation-and-certification-programs

AAAHC Health Plan Accreditation - https://www.aaahc.org/accreditation/health-plans-qhps-fehb-plans/

NCQA Health Plan Accreditation - https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/

NCQA Multicultural Health Care Distinction - https://www.ncqa.org/programs/health-plans/multicultural-health-care-mhc/

NCQA Health Plan Accreditation Process - https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/process/

NCQA Health Plan Standards and Guidelines - http://store.ncqa.org/index.php/accreditation/health-plans-hp.html

NCQA Distinction in Multicultural Health Care: Assessment of the Benefits and Recommendation to Require that Issuers Achieve this Distinction. Prepared for Covered California by Health Management Associates, August 2020. - https://hbex.coveredca.com/stakeholders/plan-management/library/NCQA-Multicultural-Health-Care-Distinction.pdf

National Accreditation Bodies and Fit for Covered California. Prepared for Covered California by Health Management Associates, September 2020.

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