

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

# HMO Quality Guide

## Measurement Year (MY 2026)

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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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](mailto:DHSDMSHMO@dhs.wisconsin.gov).

Version	Date	Change Log

## I. Measurement Year 2026 Overview

The HMO quality guide, issued by the Wisconsin Department of Health Services, Division of Medicaid Services (DMS), covers a broad range of initiatives, as shown below:



- The Wisconsin Quality Reporting (**WIQR**) initiative focuses on providing DMS healthcare quality data for a broad set of conditions and measures. WIQR does not include a withhold but does require HMOs to report data on specific quality measures and imposes financial penalties for not reporting results. DMS may use WIQR results for monitoring HMO performance, tracking progress on Managed Care Quality Strategy indicators, and in P4P measure selection.
- The Pay for Performance (**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 specific measures. These measures relate to DMS priorities or where Statewide performance is below the national 50<sup>th</sup> percentile.

- 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 benchmarks.
- The **Potentially Preventable Readmissions (PPR)** initiative supports reduction of avoidable hospital re-admissions. HMOs must work with their public and private hospital and non-hospital providers (e.g., community-based providers, home health providers, among others) to reduce their PPR rates.
- 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. Both PIPs must focus on reducing disparities among Medicaid members and compliance with the federal requirements defined in 42 CFR 438.340 (b).
- The **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** is a survey tool used to measure HMO member experience and satisfaction with care. The survey is performed annually, 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.

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](#),<sup>1</sup> 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.

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<sup>1</sup> 2025 DMS Medicaid Managed Care Quality Strategy: <https://www.dhs.wisconsin.gov/medicaid/2025-27-wi-medicaid-managed-care-quality-strategy.pdf>

## Participating HMOs

The table below lists the BadgerCare Plus (BC+) HMOs and Supplemental Security Insurance-Related Medicaid (SSI) HMOs participating in the quality initiatives for MY2026.

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 Health Plan	✓	✓
7. MercyCare HMO, Inc.	✓	
8. MHS Health Wisconsin	✓	✓
9. Molina Healthcare of WI, Inc	✓	✓
10. Network Health Plan	✓	✓
11. Quartz Health Plan Corporation	✓	✓
12. Security Health Plan of Wisconsin, Inc.	✓	✓
13. UnitedHealthcare Community Plan	✓	✓

## II. Wisconsin Quality Reporting (WIQR)

To improve alignment with current and future CMS requirements (e.g., CHIPRA, Managed Care Rules) and the WI Managed Care Quality Strategy, DMS requires all HMOs to report audited Healthcare Effectiveness Data and Information Set (HEDIS) data for measures designated as **Wisconsin Quality Reporting (WIQR)**. Aggregate performance on these measures may be used by DHS to report to CMS for any voluntary measures from the Adult and Child Core Sets. HMO performance in these measures may be used for evaluating progress towards the Managed Care Quality Strategy goals and objectives and in determining priorities for future quality initiatives (e.g. P4P or PIPs).

1. 2026 WIQR measures are all the NCQA HEDIS measures on the Medicaid IDSS template that HEDIS auditors complete on behalf of the HMOs.
2. HMOs are required to report separate HEDIS rates for each program (SSI and BC+) as well as a combined aggregate rate across their Medicaid population for all HEDIS measures and all stratifications applicable to their membership using standard HEDIS measure technical specifications.
3. HMOs should follow NCQA guidelines for denominators less than 30 for HEDIS measures.
4. HMOs could be subject to a \$10,000 penalty per measure for not reporting data for any WIQR measures as applicable to BC+, SSI, and aggregate rates.

For a full list of WIQR, P4P, and Report Card measures see Appendix D.

### Data Submission and Reporting

- All HMOs 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.
- HMOs are required to submit the following for MY 2026:
  1. 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 CSV file for each population served, in addition to a file with a combined program rate to the Secure File Transfer Portal.
  2. Data Filled Workbook, including Audit Review Table (ART) format downloaded from the NCQA IDSS site as an .xlsx file for each population served, in addition to a file with a combined program rate to DHS via email.
  3. HMOs must provide the denominators and numerators for each measure.
  4. DHS will provide HMOs with detailed submission instructions prior to submission due date. See Appendix C: Deliverables Due Dates & Submission Instructions.

## Supplemental HEDIS Fee-For-Service (FFS) Data

- At the end of each year, DMS provides data to HMOs for members who received care under FFS during the measurement year so that HMOs can get the credit for measures that rely on FFS data.
- HMOs have requested to receive this data by December, so these FFS files will not reflect the full measurement year data due to the associated claims time lags.
- DMS will provide HMOs instructions on how to submit requests for supplemental data file extracts in October 2026. HMOs must submit their request to DMS between November 1<sup>st</sup> and November 15<sup>th</sup>, 2026.
- DMS will provide the HEDIS Road Map to HMOs for the Supplemental Data file as soon as available in early December.

### III. Pay-for-Performance (P4P)

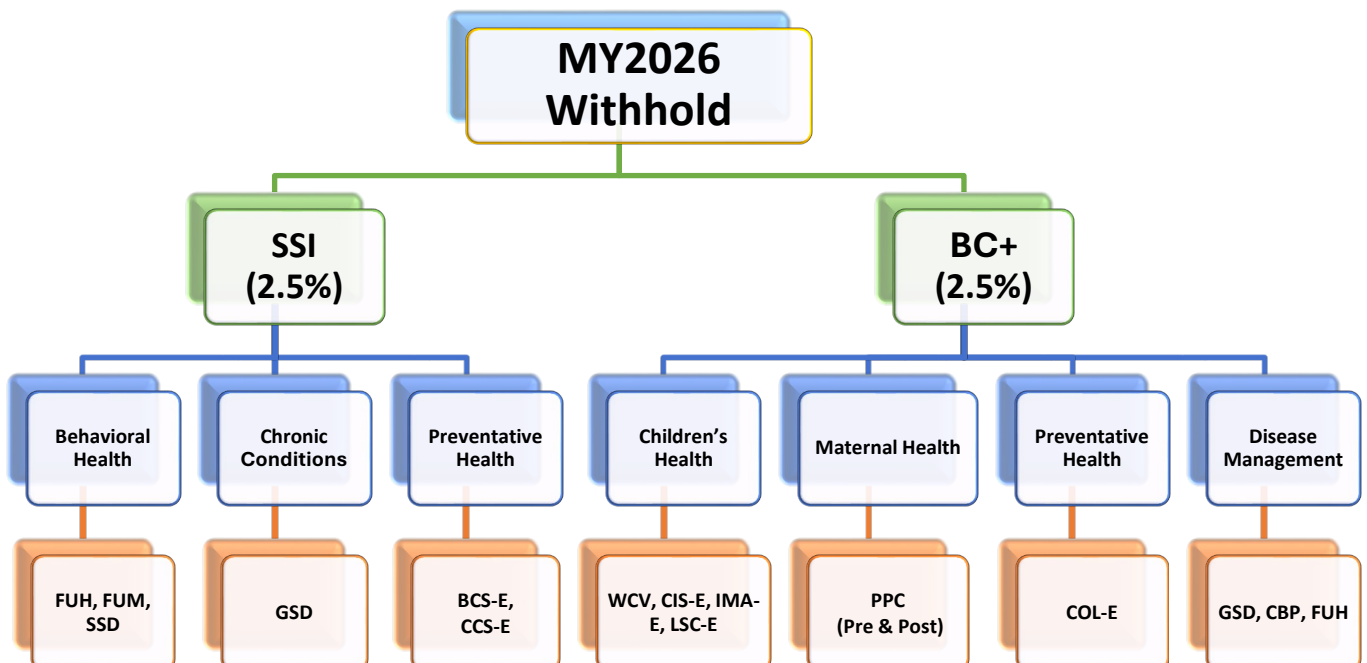
#### Scope

- **BC+:** All 6 Medicaid rate regions
- **SSI:** All 6 Medicaid rate regions

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

#### Measures, Withhold and Targets

1. The DMS uses **HEDIS measures** from HMO WIQR submissions for its P4P initiative. There will be no deviations from HEDIS specifications. Refer to HEDIS Technical Specifications published by NCQA for measure details. See Appendix C: Deliverables Due Dates & Submission Instructions for WIQR.
2. The MY 2025 upfront **withhold rate** is 2.5%. The withhold will apply to capitation for BC+ and SSI, including administrative payments.
  - a. 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).
  - b. Although the scope of the P4P does not include a separate fiscal withhold for the Childless Adult (CLA) population in BC+, CLA members are to be included in the numerators and denominators for each measure.
  - c. An HMO can also earn a bonus. See bonus calculation section below.



### 3. MY 2026 P4P Level Targets

- MY 2026 baselines for HEDIS measures are set using MY2026 HEDIS National percentiles as published in 2027 NCQA's Quality Compass (MY 2026 HEDIS data).

### 4. Reduction in Error (RIE) Targets

- Also known as Degree of Improvement, RIE targets require a baseline, established from past performance data.
- The RIE targets aim to reward HMOs that make significant improvements over time, even if their Level performance does not meet targets. RIE targets are specific to each HMO for each measure, since they are based on the past performance of each HMO.
- RIE targets are based on MY 2024 results.
- If trending breaks occur in a P4P measure such that RIE is impacted, DHS will evaluate and communicate with HMOs what the revised methodology will be for calculating RIE for that measure.
  - CIS-E, IMA-E, and CCS-E measures were reported to DHS for MY2024 and those results will be used in a RIE calculation, if needed, for MY2026.
  - MY2026 is the first year LSC-E is included in NCQA's IDSS. DHS may need to review HMOs submitted LSC (admin/hybrid) results as an alternative to LSC-E from MY2024 for baseline in RIE calculations, if needed. Methodology may be revised after results analysis and communication with HMOs.

### 5. Statewide Averages

- DHS calculates a statewide average for each measure. These averages are not used to determine P4P earnback but can be a useful tool for HMOs to see how they are performing compared to their peers.
- Calculations will be completed using the methodology outlined in CMS's Technical Assistance Resource [Calculating State-Level Rates Using Data from Multiple Reporting Units.](#)<sup>2</sup>

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<sup>2</sup> <https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf>

## MY 2026 HMO P4P Measures and Weights

BadgerCare Plus			
Measure		Weight	Area of Care
<b>Children's Health</b>		<b>1.00%</b>	
1.	Childhood Immunization (CIS-E) - Combo 3	0.25	Primary Care Access and Preventative Care
2.	Immunizations for Adolescents (IMA-E) - Combo 2	0.25	
3.	Lead Screening in Children (LCS-E)	0.25	
4.	Child and Adolescent Well-Care Visits (WCV)- Total	0.25	
<b>Maternal Health</b>		<b>0.50%</b>	
5.	Prenatal Care (PPC)	0.25	Maternal Health
6.	Postpartum Care (PPC)	0.25	
<b>Disease Management</b>		<b>1.00%</b>	
7.	Colorectal Cancer Screening (COL-E) - Total	0.25	Preventative Health
8.	Glycemic Status Assessment for Patients with Diabetes (GSD) – Control <8%	0.25	Chronic Conditions
9.	Controlling Blood Pressure (CBP)	0.25	
10.	Follow up within 30 days after hospitalization for mental illness (FUH) – Total, 30-day follow-up	0.25	Behavioral Health

SSI			
Measure		*Weight	Area of Care
<b>SSI</b>		<b>2.50%</b>	
1.	Follow up within 30 days after hospitalization for mental illness (FUH) – Total, 30-day follow-up	0.42	Behavioral Health
2.	Follow up within 30 days after ED admission for mental illness (FUM) – Total, 30-day follow-up	0.42	
3.	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	0.42	
4.	Glycemic Status Assessment for Patients with Diabetes (GSD)– Control <8%	0.42	Chronic Conditions
5.	Breast Cancer Screening - Total (BCS-E)	0.42	Preventative Health
6.	Cervical Cancer Screening (CCS-E)	0.42	

*\*Weight is rounded for display purposes. Earnback calculations will be made using exact weight of 2.5% divided by 6 measures = .416666666666%*

## P4P Methodology

The same methodology applies to all measures.

### 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.

If an HMO does not earn points for its level of performance, it can earn 0 to 2 points based on its reduction in error.

- 2 points if below the national 50th percentile but with a 10% or greater reduction in error from the HMO's 2024 performance.
- 1 point if below the national 50<sup>th</sup> percentile but with a 5% or greater reduction in error from the HMO's 2024 performance.

Point Matrix			
Over 75% nationally	4		
67-74% nationally	3		
50-67% nationally	2		
RIE Point Matrix	<5% increase over 2024 results	5-9.9% increase over 2024 results	10% ≥ increase over 2024 results
<50% nationally	0	1	2

RIE percentage is calculated using the following formula:

$$\% \text{ RIE for MY 2026} = \left\{ \frac{\text{MY2026} - \text{MY2024}}{\text{Error}} \right\} \times 100, \text{ Where Error} = (100 - \text{MY2024})$$

### 2. Earning back the withhold:

- An HMO can receive between 0 and 4 points for each measure.
- The proportion of the earnback for the measure is equal to the points earned divided by 4 (maximum number of points) multiplied by the measure weight.

$$\text{Percentage of earnback} = \left\{ \frac{\text{Points Earned}}{\text{Maximum Points Possible}} \right\} \times \text{Measure Weight}$$

- The total earnback rate is the sum of the earnback proportions of all the measures in the P4P population.

- 3. Small denominators:** HMOs should follow NCQA guidelines for denominators less than 30. An HMO with less than 30 observations in the denominator for a measure will forfeit the full amount withheld for that measure.
- A 3-year grace period will start on 1/1/2026, whereas the first measurement year that this will go into effect will be MY2029. Plans will still receive full earnback for measures with small denominators, with MY2029 being the first year of forfeiture.
  - New HMO contracts will have a 3-year grace period starting on the date the contract is in effect to increase their membership before small denominator forfeiture goes into effect.

- 4. Example Calculation:** Table 1 below shows points and earnback calculation examples for two hypothetical HMOs using BadgerCare+.

- **HMO A:**

Individual measure calculation: HMO A earned 2 points for the CBP measure as the rate achieved was between the 50<sup>th</sup> and 67<sup>th</sup> national percentile. The maximum points available for CBP is 4. Using the *Percentage of Earnback* equations above, HMO A earns back 50% of the measure weight for CPB (.25), for a total of .13%.

Total Earnback Calculation: The sum of the 10 individual measure earnback percentages for BC+ = 1.41%, therefore HMO A earns back 1.41% out of the maximum 2.5% earnback for the BC+ withhold (shown in the last row of the table).

- **HMO B:**

Individual measure calculation: HMO B achieved 55% for the CBP measure, which was below the 50<sup>th</sup> national percentile. Therefore, the *RIE equation* listed above was used and the HMO achieved an 8.2% reduction in error worth 1 point.

$$\% \text{ RIE for CBP} = (55-51)/(100-51) = 8.2\%$$

The maximum points available for CPB is 4. Using the *Percentage of Earnback* equation above, HMO B earns back  $\frac{1}{4}$  of the CBP measure weight (.25) for a total of .06.

Total Earnback Calculation: The sum of the 10 individual measure earnback percentages for BC+ = 2.01%, therefore HMO B earns back 2.01% of the maximum 2.5% earnback for the BC+ withhold (shown in the last row of the table).

Table 1: Example Calculations

Measure (Weight)	<i>Hypothetical</i> MY2026 Level Targets			RIE Targets when HMO 2026 performance is below the national 50 <sup>th</sup> percentile		Example Points and Earnback %			
	≥75 <sup>th</sup>	≥67 <sup>th</sup>	≥50 <sup>th</sup>						
	4 points	3 points	2 points	2 points	1 point	HMO A Points	HMO A Earnback %	HMO B Points	HMO B Earnback %
<b>CIS Combo 3 (0.25)</b>	≥ 69.9%	≥ 67.4%	≥ 64.0%	RIE is 10% ≥ over 2024 results	RIE is 5.0-9.9% increase over 2024 results	2026 Results = 69.2% Points= 3	$(3/4) * .25 = .19$	2026 Results= 70.3% Points= 4	$(4/4) * .25 = .25$
<b>IMA Combo 2 (0.25)</b>	≥ 40.9%	≥ 38.9%	≥ 34.3%	RIE is 10% > over 2024 results	RIE is 5.0-9.9% increase over 2024 results	2026 Results = 42.3% Points = 4	$(4/4) * .25 = .25$	2026 Results= 41.1% Points = 4	$(4/4) * .25 = .25$
<b>LSC-E (0.25)</b>	≥ 70.1%	≥ 67.1%	≥ 62.8%	RIE is 10% ≥ over 2024 results	RIE is 5.0-9.9% increase over 2024 results	2026 Results =68.4% Points= 3	$(3/4) * .25 = .19$	2026 Results= 73.8% Points= 4	$(4/4) * .25 = .25$
<b>WCV (0.25)</b>	≥ 55.1%	≥ 51.8%	≥ 48.1%	RIE is 10% ≥ over 2024 results	RIE is 5.0-9.9% increase over 2024 results	2026 Results =44.2% 2024 Results =38.0% (10.0% RIE) Points= 2	$(2/4) * .25 = .13$	2026 Results=38.0% 2024 Results=27.8% (14.1% RIE) Points= 2	$(2/4) * .25 = .13$
<b>PPC – Pre (0.25)</b>	≥ 88.3%	≥ 86.9%	≥ 84.2%	RIE is 10% ≥ over 2024 results	RIE is 5.0-9.9% increase over 2024 results	2026 Results = 86.0% Points= 2	$(2/4) * .25 = .13$	2026 Results = 89.4% Points= 4	$(4/4) * .25 = .25$
<b>PPC – Post (0.25)</b>	≥ 82.0%	≥ 80.8%	≥ 78.1%	RIE is 10% ≥ over 2024 results	RIE is 5.0-9.9% increase over 2024 results	2026 Results =79.3% Points= 2	$(2/4) * .25 = .13$	2026 Results =81.2% Points= 3	$(3/4) * .25 = .19$

Measure (Weight)	<i>Hypothetical</i> MY 2026 Level Targets			RIE Targets when HMO 2026 performance is below the national 50 <sup>th</sup> percentile		Points and Earnback %			
	≥75 <sup>th</sup>	≥67 <sup>th</sup>	≥50 <sup>th</sup>	2 points	1 point	HMO A Points	HMO A Earnback %	HMO B Points	HMO B Earnback %
	4 points	3 points	2 points						
<b>COL-E (0.25)</b>	≥ 70.8%	≥ 69.4%	≥ 65.6%	RIE is 10% ≥ over 2024 results	RIE is 5.0-9.9% increase over 2024 results	2026 Results =62.0% 2024 Results =6.0% <i>No RIE because 2026 results lower than 2024 results</i> Point=0	(0/4)*.25 = .00	2026 Results = 69.8% Points= 3	(3/4)*.25 = .19
<b>GSD (0.25)</b>	≥ 57.2%	≥ 55.7 %	≥ 52.3%	RIE is 10% ≥ over 2024 results	RIE is 5.0-9.9% increase over 2024 results	2026 Results =53.8% Points= 2	(2/4)*.25 = .13	2026 Results = 56.1% Points= 3	(3/4)*.25 = .19
<b>CBP (0.25)</b>	≥ 67.3%	≥ 65.5%	≥ 61.3%	RIE is 10% ≥ over 2024 results	RIE is 5.0-9.9% increase over 2024 results	2026 Results =62.4% Points= 2	(2/4)*.25 = .13	2026 Results=55.0% 2024 Results=51.0% (8.2% RIE) Points= 1	(1/4)*.25 = .06
<b>FUH-30 (0.25)</b>	≥ 65.4%	≥ 63.5%	≥ 57.7%	RIE is 10% ≥ over 2024 results	RIE is 5.0-9.9% increase over 2024results	2026 Results =62.1% Points = 2	(2/4)*.25 = .13	Denominator < 30 Points=4	(4/4)*.25 = .25
<b>Total BC+ Earnback % (Maximum 2.50%)</b>							<b>1.41%</b>		<b>2.01%</b>

## 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.

An HMO must meet all 3 of the following requirements to be eligible for the bonus.

1. The HMO has reported data for all WIQR measures, regardless of the denominator size.
2. Have a minimum number of P4P measures with a denominator  $\geq 30$ .
  - BC+ - Minimum 8 out of the 10 P4P measures
  - SSI - Minimum 5 out of the 6 P4P measures
3. HMO must earn back 100% of its BC+ withhold to be eligible for the BC+ bonus. HMO must earn back 100% of the SSI withhold to be eligible for the SSI bonus.

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
<b>Total</b>	<b>4000</b>	<b>100%</b>	<b>\$2 million</b>

## IV. HMO Report Card

DMS intends to publish two separate Report Cards: one for SSI and one for BadgerCare Plus.

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 to national benchmarks relative to other WI Medicaid HMOs

The HMO Report Card is publicly available on [ForwardHealth](#)<sup>3</sup>. DMS anticipates that Report Cards will be published in the 4<sup>th</sup> quarter of the HMO submission year (e.g., the 2026 results Report Card, using data submitted to DMS in July 2027, will be published in Q4 2027).

### 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 all Medicaid HMOs nationally, as published by NCQA in 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, 3/4 <sup>th</sup> ) 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, 2/3 <sup>rd</sup> ) 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, 1/3 <sup>rd</sup> ) of all Medicaid plans in the nation.
★☆☆☆☆ = Poor	HMO performed in the lowest 1/3 <sup>rd</sup> of all Medicaid plans in the nation.

<sup>3</sup>[https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality\\_for\\_BCP\\_and\\_Medicaid\\_SSI/Home.htm.spage](https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/Home.htm.spage)

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.**

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

DHS intends to publish the report cards using the HEDIS measures and stratifications designated for each area of care as indicated in the below table. If DMS needs to change this list (such as to replace a measure due to NCOA changes or insufficient data, or to add a measure based on clinical priority), HMOs will be informed of any changes during the development of the 2026 HMO report card (anticipated in the fall of 2027).

Note: When calculating the number of stars an HMO earned, DMS uses the HEDIS rates as reported. No rounding up or down is performed for result calculations. Star ratings, however, will be rounded to 1 decimal point for publication of the overall score.

Anticipated Measures for 2025 HMO Report Card			
Area of Care	Quality Measure	BC+	SSI
Staying Healthy	Breast Cancer Screening (BCS-E, total)	Applicable	Applicable
	Childhood Immunization (CIS-E, combo 3)	Applicable	N/A
	Cervical cancer screening (CCS-E)	Applicable	Applicable
	Chlamydia screening (CHL, total)	Applicable	Applicable
	Colorectal Cancer Screening (COL-E)	Applicable	Applicable
	Immunizations for Adolescents immunization (IMA-E, combo 2)	Applicable	N/A
	Lead screening in children (LSC-E)	Applicable	N/A
	Well-Child Visits in the First 30 Months of Life (W30)	Applicable	N/A
	Child and Adolescent Well-Care Visits (WCV, total)	Applicable	N/A
Living With Illness	Controlling Blood Pressure (CBP)	Applicable	Applicable
	Glycemic Status Assessment for Patients with Diabetes (GSD, control <8%)	Applicable	Applicable
Mental Health Care	Follow-up after ED visit for alcohol and other drug abuse or dependence (FUA, Total, 30 days)	Applicable	Applicable
	Follow-up after Hospitalization for Mental Illness (FUH, Total, 30 days)	Applicable	Applicable
	Follow-up after ED visit for mental illness (FUM, Total, 30 days)	Applicable	Applicable
	Initiation and Engagement of SUD Treatment- Engagement of SUD treatment (IET, Total ages (Total))	Applicable	Applicable
	Adherence to antipsychotic medications for individuals with schizophrenia (SAA)	Applicable	Applicable
Hospital and ED Care	Plan all-cause readmissions (PCR, Observed Total 18-64/Expected Total 18-64)	Applicable	Applicable
Pregnancy & Birth-related Care	Prenatal Care & Postpartum Care (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**. HMOs are displayed from highest overall ratings to lowest overall ratings.
4. Measures with small denominators (<30) will alter the HMO Report Card methodology as follows:
  - AOC scoring; a plan must have a scorable rate in at least 50% of the measures in each AOC to receive a star rating. N/A will be used to represent any AOC that does not have sufficient data to receive a star rating

- Overall scoring; a plan must have a scorable rate in at least 75% of individual measures across all areas of care to receive an overall rating. N/A will be used in all AOC and the overall rating when this provision is applied.
- Report Card Display: will show plans without a calculated overall score at the bottom of the list (if multiple plans, the plans will be placed in alphabetical order).

### Example of BadgerCare+ Report Card

BadgerCare Plus HMO	Hospital and ED Readmissions	Living with Illness	Mental Health	Pregnancy & Birth	Staying Healthy	Overall Score (out of 5)
HMO B	★★★★★	★★★★	★★★★★	★★★★★	★★★★	4.0
HMO C	★★★★★	★★★	★★★★	★★★★★	★★★	3.5
HMO A	★	★★★	★★★★	★★★	★★★	2.8
HMO D	★	★★	★★★★	★★	★★★★	2.8
HMO E	★	★★★	★★★	★★★	★★	2.5
HMO G	★★★	★★	★★★	★	★★	2.2
HMO F	★★	★	★★★	★	★	1.8
All Wisconsin BC+ HMOs	★★★	★★	★★★★	★★★	★★	2.8

### Example of SSI Report Card

Medicaid SSI HMO	Hospital and ED Readmissions	Living with Illness	Mental Health	Staying Healthy	Overall Score (out of 5)
HMO E	★★★★★	★★★★	★★★★	★★★★★	3.9
HMO B	★★★★	★★★★	★★★★	★★	3.3
HMO C	★	★★★	★★★★	★★★★	3.1
HMO A	★	★★★★	★★★	★★★	2.9
HMO D	★	★★★	★★★	★★	2.6
All Wisconsin SSI HMOs	★★	★★★	★★★★	★★★	3.2

## V. Potentially Preventable Readmissions (PPR)

### 1. Overview of the HMO PPR Initiative

HMOs must work with their public and private hospital and non-hospital providers (e.g., community-based providers, home health providers, among others) to reduce their PPR rates.

### 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 paid on a DRG basis 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).
- 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.

#### 4. HMO PPR Initiative

- a. **Population in scope:**  
MY 2026 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.  
$$\% \text{ reduction in ABR} = \frac{[\text{Baseline ABR} - \text{MY ABR}]}{[\text{Baseline ABR}]}$$

HMO ABR value used for baseline is shown in row *K* in the HMO BC+ PPR Summary report shared by DMS with the HMOs.

Numerator = QAs with associated PPR (Initial Admissions), shown in row *E1* in the HMO BC+ Summary PPR report

Denominator = Benchmark PPR Chains, shown in row *I* in the HMO BC+ PPR Summary 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 2026:**

**MY 2024 HMO-specific ABR performance results** will be used to establish the baselines for MY 2026, 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. **Incentive**

For MY 2026, 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 percentage % reduction in their ABR, as value-based payments. HMOs that do not meet the target will not receive any PPR incentive funds.

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; DMS also encourages HMOs to collaborate with other HMOs to identify joint focus areas to reduce PPRs with common providers.

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. The Department 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  $\leq 0.95$
- Tier 2 = Middle performance HMOs, with baseline ABR  $\Rightarrow 0.96$  but  $\leq 1.05$
- Tier 3 = Low performance HMOs, with baseline ABR  $\Rightarrow 1.06$

The Tiers above also create confidence intervals for the methodology.

#### **HMOs with low ABR ( $\leq 0.85$ ):**

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  $\leq 0.85$  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.

BadgerCare Plus 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)		
	<i>Tier 1 - High performance HMOs</i>	<i>Tier 2 - Middle performance HMOs</i>	<i>Tier 3 - Low performance HMOs</i>
<b>100%</b>	5% or more	7% or more	10% or more
<b>75%</b>	3% to 4.9%	4% to 6.9%	7% to 9.9%
<b>50%</b>	1% to 2.9%	2% to 3.9%	4% to 6.9%
<b>25%</b>	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.

<b>HMO PPR - HYPOTHETICAL EXAMPLE</b>									
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 =  $(\text{Column 5} - \text{Column 7}) / \text{Column 5}$ .
- 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  $\leq 0.85$  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  $\leq 0.95$ ) in the next cycle.

PPR incentive payments for MY 2026 will be disbursed in 2027, 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 incentive 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 MY 2026, 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 MY 2026. 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):

- i. **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.

- j. **Preliminary annual reports:** HMOs will receive “preliminary” annual reports about 5.5 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.
- k. **Final annual reports:** HMOs will receive the “final” annual reports about 9.5 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:
<b>2025</b>			
1/1 – 3/31	5/15/2025	5/15/2025 (data for MY 2024)	N/A
4/1 – 6/30	8/15/2025	N/A	N/A
7/1 – 9/30	11/15/2025	N/A	N/A
10/1 – 12/31	2/15/2025	N/A	N/A
<b>2026</b>			
1/1 – 3/31	5/15/2026	5/15/2026 (data for MY 2025)	N/A
4/1 – 6/30	8/15/2026	N/A	N/A
7/1 – 9/30	11/15/2026	N/A	9/15/2026 (data for MY2025)
10/1 – 12/31	2/15/2027	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.

- **Quality Measure Utilization Analysis of specific care management services** (Specific HCPCS 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 may be included in publicly available quality reports, such as the Annual EQR Technical Report and Managed Care Quality Strategy.

### Quality Measure Utilization Analysis

DMS has developed quality measures that utilize encounter data with HCPCS G code procedure codes submitted by the HMOs to evaluate how well the care management services delivered by the HMOs meet the program objectives. Measure results data will be analyzed to compare HMOs performance and to evaluate overall effectiveness of the initiative.

DMS will share quality measurement data with HMOs.

See the SSI Care Management Billing Guide for information on billing requirements for the specified HCPCS G code series for SSI Care Management Services. 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](https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Reimbursement%20and%20Capitation/Home.htm.spage#ssicmbg)

HMO SSI Care Management performance will be calculated using the following quality measures:

1. Care Planning (CP1) = % of new members had a care plan billed 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
<p><b>Care Planning</b></p>	<p><b><u>New members</u></b>  <i>(enrolled after 1/1/2026; not enrolled in the same HMO for the past 6 months or longer):</i></p> <p><b>(CP1): % of new members with care plans within 90 days of enrollment</b>            = # of new members with care plans within 90 days of enrollment / # of new members with 90+ days of continuous enrollment  <b>Calculated quarterly by DMS using code G9001</b></p> <p>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.</p> <p>This measure tracks new members to the HMO only. See the billing guide for G9001 billing specifications.</p>
<p><b>Needs Stratification</b></p>	<p>Use Care Management (G) codes 9002, 9006, 9007 or 9012;  <b>Calculated by month by DMS after data submission deadline:</b></p> <p><b><u>WICT (up to 5% of SSI membership)</u></b>  <i>Data point 1: # of unique members billed each month with <u>G code (G9002, G9006, G9007, or G9012) + TG modifier (= WICT stratum)</u></i></p> <p><b>(NS1): % enrollment in WICT for each month</b>            = Data point 1 / total # of members enrolled for that month            (Assumption: each member in WICT receives at least one WICT related service each month)</p> <p><b>(NS2): Average % enrollment in WICT over last 12 months<sup>SEP</sup></b>            = Sum of Data point 1 over last 12 months / # of total member months over last 12 months</p> <p><b>(NS3): Average # of months in WICT over last 12 months</b>            = 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</p>

Step	Data Reporting Description
	<p><i>Create a histogram for NS3 (# of months and corresponding # of members)</i></p> <p><b><u>Medium stratum (next highest after WICT)</u></b>  <i>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.</i></p> <p><b>(NS4): % enrollment in Medium stratum for each month</b>  = Data point 2 / total # of members enrolled for that month</p> <p><b>(NS5): Average % enrollment in Medium stratum over last 12 months</b>  = Sum of Data point 2 over last 12 months / total # of member months over last 12 months</p> <p><b><u>Lower stratum (all combined after Medium)</u></b>  <i>Data point 3: # of unique members each month with any G code + no modifier (= all combined Lower stratum). There is no payment difference between TF modifier and no modifier.</i></p> <p><b>(NS6): % enrollment in Lower stratum for each month</b>  = Data point 3 / total # of members enrolled for that month</p> <p><b>(NS7): Average % enrollment in Medium stratum over last 12 months</b>  = Sum of Data point 3 over last 12 months / total # of member months over last 12 months</p>
Transition Care	<p><b>Calculation annually by DMS</b></p> <p><i>Data point 4: Total # of discharges from inpatient stay during the reporting period</i></p> <p><i>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</i></p> <p><i>Create a frequency distribution / histogram for data point 5 (# of days for follow-up)</i></p> <p><b>(TC1): % of all discharges from inpatient stay with a follow-up Transition Care service</b>  = Sum of Data point 5 / Data point 4</p> <p><b>(TC2): Timeliness of Transition Care (within 5 days of discharge)</b>  = % 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</p>

## Qualitative EQRO Review of SSI Care Management Process Quality

### EQRO SSI Care Management Review Process Overview

The External Quality Review Organization (EQRO) conducts the SSI Care Management Review to assess Health Maintenance Organization (HMO) compliance with the care management requirements outlined in the BadgerCare Plus (BC+) and Medicaid SSI HMO Contract.

### Review Schedule and Timeframes

Using enrollment data, the EQRO will generate member samples for each HMO. Reviews will be conducted throughout the calendar year, with one to two HMOs reviewed per month.

- **For reviews conducted between January 1 and June 30, 2026**, the review period will cover **January 1, 2025, through December 31, 2025**.
- **For reviews conducted between July 1 and December 31, 2026**, the review period will cover **July 1, 2025, through June 30, 2026**.

### Sampling Methodology

The EQRO will randomly select member records to ensure a representative sample. The sample will include:

- Members newly enrolled within the past year,
- Members continuously enrolled for more than 90 days, and
- Members who have disenrolled since the sample was generated.

The sample will be stratified to include members in the Wisconsin Interdisciplinary Care Team (WICT), as well as those in medium and low care management strata. Sample sizes will be determined based on population size, using an 80% confidence level and a 5% margin of error.

### Review Tools and Focus Areas

EQRO reviewers are trained to use DHS-approved tools, guidelines, and databases. The review process is grounded in DHS contract requirements and care management training materials. In addition to identifying any immediate health or safety concerns, the review evaluates four core areas of care management:

- **Screening**
- **Care Planning**
- **Care Coordination**
- **WICT Structure and Processes**

### Reporting and Follow-Up

Upon completion of each review, the EQRO will submit:

- A report outline,
- A final determination report, and
- Any additional documentation requested by the Department of Health Services (DHS).

Each HMO will be given the opportunity to respond to the findings and provide feedback on the review results.

See Appendix I to review the current year's EQRO's Care Management Review tool, which includes the SSI CMR review indicators, scoring methodology, guidance, and indicator source citation.

## VII. Performance Improvement Projects

HMOs must conduct two Performance Improvement Projects (PIPs) each year. See the [current HMO contract](#) for additional information. HMOs must work with DMS's EQRO, MetaStar, to meet specific, CMS-defined project requirements. CMS's External Quality Review (EQR) Protocols<sup>4</sup> may be a helpful reference in developing the PIP.

- By the first business day in November, HMOs must use the online application accessed via MetaStar's portal to submit proposal information for review and approval.
- By the first business day in July, HMOs must submit PIP final reports using the template provided in Appendix H.

The EQRO PIP Standards and Scoring, PIP Scoring Aggregate Report Example, and PIP Rating Scales are useful tools for HMOs in developing their PIP proposals and final reports. See Appendices E, F, and G.

Training that addresses foundational requirements, current expectations, and common questions on PIPs is available through the PIP Requirements Training<sup>5</sup>. HMOs' PIP topics, aim statements, and improvement strategies are published annually on the Quality for BadgerCare Plus and Medicaid SSI webpage<sup>6</sup> under Performance Improvement Projects (PIPs). HMOs can review this information and reach out to each other with questions, collaboration ideas, etc.

### 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 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 the Wisconsin State Health Improvement Plan 2023--2027.<sup>7</sup> CMS also specifically requires reduction in health disparities to be a part of the State's quality strategy<sup>8</sup>, and Wisconsin's 2025-2027 Quality Strategy includes sections on health disparities and PIPs<sup>9</sup>.

<sup>4</sup> CMS External Quality Review (EQR) Protocols: <https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf>

<sup>5</sup> PIP Requirements Training: <https://vimeo.com/showcase/9388305>

<sup>6</sup> [https://www.forwardhealth.wi.gov/WIPortal/content/ManagedCareOrganization/Quality\\_for\\_BCP\\_and\\_Medicaid\\_SSI/Home.htm.spage](https://www.forwardhealth.wi.gov/WIPortal/content/ManagedCareOrganization/Quality_for_BCP_and_Medicaid_SSI/Home.htm.spage)

<sup>7</sup> <https://www.dhs.wisconsin.gov/publications/p0/p00187.pdf>

<sup>8</sup> <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/state-quality-strategies/index.html>

<sup>9</sup> <https://www.dhs.wisconsin.gov/medicaid/medicaid-managed-care-quality-strategy-20252027.pdf>

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.”<sup>10</sup> Economic resources and geographical location have a proven sizable impact on health outcomes, and so partnerships between communities and the health care system are critical for improving health across the lifespan and reducing disparities in health outcomes. Having data on the unmet social needs of individuals and using that data to connect to existing community resources and strengthen evidence-based partnerships that improve whole-person health is foundational to any effort to eliminate disparities.

## PIP Structure

Per federal requirements, HMOs must complete one clinical project and one non-clinical project. HMOs that serve both BC+ and SSI populations can include both populations in their PIPs. HMOs that choose this option must include separate baseline and target data for each population in their proposal (with two separate aim statements) and report data separately in their final PIP reports.

Options for HMOs serving BC+ **and** SSI Populations:

Option	Clinical Topic	Non-Clinical Topic
1	BC+ Population	SSI Population
2	SSI Population	BC+ Population
3	BC+ <b>AND</b> SSI Populations	BC+ Population <b>OR</b> SSI Population
4	BC+ Population <b>OR</b> SSI Population	BC+ <b>AND</b> SSI Populations
5	BC+ Population <b>AND</b> SSI Population	BC+ Population <b>AND</b> SSI Population

## Topic Selection

HMOs must select a topic for each PIP where there is an identified 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 measures but could include any performance measure (including a HEDIS® measure, a care management measure, or CAHPS result). PIP aim statements should be focused on reducing the disparity for the target population. The target population must be the underrepresented or socially disadvantaged population. HMOs should describe the method they use for soliciting and incorporating input from members, providers, and other interested parties on the design and implementation of their PIPs in the proposals and final reports. HMOs may not create a PIP that is designed to collect baseline data to evaluate whether a disparity exists.

DMS has the authority to select PIP topics. Additionally, CMS, in consultation with DMS and the HMOs, may specify performance measures and topics for PIPs. HMOs will receive advance notice if a PIP topic will be assigned.

<sup>10</sup> [Health Care Steps Up to Social Determinants: Current Context](#)

## Considerations

### Multi-year PIPs

HMOs can propose multi-year PIPs that meet all PIP structure and topic selection requirements. HMOs must submit a proposal for review and approval each year and, per federal requirements, an annual report for validation each year. HMOs should consider how they will incorporate what was learned through PDSA cycles and interim measurements in year one in the proposal for year two. While the aim statement and measure can be the same, improvement strategies must be updated, adjusted, or advanced based on the previous year's project. For example, what changes are being made to the improvement strategy because of what was learned in year one? How is input from members and project partners being incorporated in year two?

### Collaborative PIPs

HMOs can satisfy one of its PIP requirements by actively participating in a collaborative PIP in conjunction with one or more HMOs. Topics for collaborative PIPs may be specified by DMS or by consensus agreement of the HMO participants. The topic must be founded on a sufficient needs assessment reflective of each participating HMO's membership and must meet all PIP structure and topic selection requirements. HMOs participating in a collaborative PIP shall establish the parameters of the project design, implementation, data analysis, evaluation, and sustainability of improvements as achieved. The project plan shall be submitted to DMS for approval prior to project implementation. Each HMO participating in a collaborative PIP is required to submit a separate, final report, with separate HMO-specific data and analysis, for validation.

### Community-Based Organizations

HMOs should consider how partnerships with community-based organizations (CBOs) can address the identified disparity when selecting a topic. HMOs may continue to partner with CBOs from prior PIPs or are encouraged to develop new partnerships based on the PIP topic, target population, and intervention strategies selected. If HMOs partner with CBOs, they should include a description of the role the CBO has in the PIP. Suggested considerations include:

- How the CBO addresses a social determinant need relevant to the target PIP population and aim.
- How the CBO contributes to culturally and linguistically appropriate service provision; for example, assisting with focus groups designed to gather member feedback or providing training to HMO and provider staff.

## 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. Behavioral health and substance abuse screenings and management
5. Blood lead testing
6. Breast cancer screening
7. Childhood immunizations
8. Childhood obesity interventions
9. Dental Care
10. Diabetes management
11. Emergency department utilization
12. Health outcome improvements in chronic conditions, preventative care, primary care, behavioral health, etc. through care team extensions (e.g., community health workers, doulas, health coaches, etc.)
13. Hypertension management
14. Prenatal and postpartum depression screening and follow-up
15. Preventable hospital readmissions
16. Tobacco cessation
17. Well Child Visits

**Suggested Non-Clinical Topics**

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

## 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. As part of NCQA Medicaid HMO accreditation requirements, HMOs must administer CAHPS.

HMO CAHPS results will be used to fulfill federal Child and Adult Core Set measure reporting and to evaluate HMO program and plan performance on member experience and satisfaction with care. The Department will make CAHPS survey results available to current and potential members, including but not limited to the publicly posted Quality Rating System.

See the current HMO contract for policy requirements. This section provides additional information on the technical details of the annual surveys.

### Survey Instrument Administration

The HMO's vendor must administer surveys by population(s) served as follows:

1. Adult Medicaid: CAHPS Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)
2. Child Medicaid (including Medicaid-expansion CHIP – Title XIX): CAHPS Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)
  - General child (GC) population
  - Children with Chronic Conditions (CCC) population
3. CHIP (Separate-CHIP – Title XXI): CAHPS Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)
  - General child (GC) population
  - Children with Chronic Conditions (CCC) population

Notes on the child survey instruments:

- NCQA considers the CAHPS Child Medicaid Children with Chronic Conditions its own distinct survey although the core questions are identical to child Medicaid.

CMS' clarification about the Child CAHPS requirements within the Child Core Set measures: The CAHPS Health Plan Survey - Child Medicaid version contains the Children with Chronic Conditions (CCC) supplemental item set. The Child Medicaid survey instrument includes a screener, to identify children with a chronic condition, and a set of supplemental questions regarding the health care experiences of children with chronic conditions. Health plans that include the CCC supplemental items draw a sample of children in the general population as well as a supplemental sample of children identified through a claims-based algorithm as being likely

to have a chronic condition. Children originally selected for the CCC supplemental sample who did not meet the CCC survey-based screening criteria will be included in the general child population results.

### Child Survey Stratification

Per CMS Child Core Set requirements, results for the child surveys must be stratified with two rates reported: Medicaid and CHIP. In Wisconsin, the BadgerCare Plus HMO program includes both Medicaid and CHIP populations.

The following medical status codes indicate which BadgerCare Plus members should be included in the CHIP stratification for the child survey results:

Medical Status Code	Medical Status Code Description
9K	Child, 1-18, >200-250%
9L	Child, 1-18, >250-300%
9Z	12 mo. CHIP extension, child <19
BG	Child, 6 - 18, >150-200%, BC+ SP
C3	Child, 1-5, >185-200%, BC+ SP
T8	Child 1-18, >200-250%, tribal member
T9	Child 1-18, >250-300%, tribal member
TF	Child, ages 1-5, tribal member
TG	Child, ages 6-18 tribal member

All other BadgerCare Plus HMO children would be included in the Medicaid stratification for the child survey results.

### Sample Population

- a. The HMO must include the full eligible plan population in the survey sample.
- b. Allowable population exclusions: If the HMO excludes any populations in its sampling, it should note that exclusion in its results submission to DHS.
  1. Per NCQA reporting requirements in Volume 3, the HMO may exclude members who have other insurance commercial coverage as a primary payer before Medicaid or CHIP. If the plan has dual Medicare and Medicaid coverage, and the member is enrolled in the plan's Medicare contract required to report HEDIS

and in the plan's Medicaid managed-care contract, then the member must be included in the Medicaid report. If the dual eligible member has Medicare Private Fee-for-Service (PFFS) through another health plan or unknown Medicare coverage as their primary, then the member may be excluded from the Medicaid report.

2. Per CMS Core Set measure reporting requirements, all eligible members should be included in mandatory measure reporting, including CAHPS sampling. However, CMS has provided state guidance that these populations are voluntary for reporting. Therefore, HMOs may include or exclude members who have other insurance coverage as a primary payer before Medicaid or CHIP, including individuals dually eligible for Medicare and Medicaid.
- c. The HMO must identify Spanish speaking members through administrative data and ensure those members who are included in the CAHPS sample receive the Spanish version of the survey.

### CAHPS Survey Vendor Requirements

- a. The HMO must contract with a vendor certified by NCQA to perform annual CAHPS surveys. A list of NCQA-certified HEDIS CAHPS survey vendors can be found here and is updated annually by November: <https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/cahps-5-1h-survey-certification/vendor-directory/>.
- b. To be compliant with HEDIS protocols for data submitted to NCQA, HMOs and the vendor must administer required Medicaid surveys using the most current CAHPS version specified by NCQA. Survey and administration specifications must be consistent with NCQA's specifications as listed in HEDIS Volume 3: Specifications for Survey Measures.
- c. HMOs and their vendors should also reference CMS' annually published measure requirements specific to CAHPS measures used within the Adult and Child Core Sets. CMS' resource manuals indicate the survey version that should be used and includes a sample survey questionnaire and survey protocol information. The 2026 resource manuals will be available on the CMS website in early 2026. For reference, the 2025 resource manuals can be found here:

Adult Core Set: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf>

Child Core Set: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf>

## DHS Data Submission

While the HMO must follow NCQA requirements for submission of results to NCQA as required for accreditation, the HMO must also submit the results during the June submission period to the AHRQ survey database, per the HMO Contract.

HMOs must provide a copy of their results to DMS. A copy of the Final Results Report (.pdf) and the Deidentified Member File (.csv) must be emailed to [DHSDMSHMO@dhs.wisconsin.gov](mailto:DHSDMSHMO@dhs.wisconsin.gov) by 6/30/2026.

## CAHPS FAQ

### **Do HMOs need to obtain DHS and/or CMS approval on your CAHPS survey approach?**

No, prior approval of your survey projects is not required by DMS or CMS. DMS or CMS does not need to review your project methodology or survey administration details.

### **Do HMOs need to do two separate Child survey sample frames to account for CHIP vs. Medicaid?**

Yes. Per CMS, states are required to sample Title-XXI funded M-CHIP populations with Title-XIX funded Medicaid populations (including Children with Chronic Conditions (CCC) supplemental item set), and a separate sample of the separate CHIP (S-CHIP) population (including Children with Chronic Conditions (CCC) supplemental item set). HMOs can refer to the CMS CAHPS FAQ Sheet for more information: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsfactsheet.pdf>

### **Is it permissible to include both BC+ and SSI HMO adults in the Adult survey sample, without further stratification?**

Yes.

### **Do HMOs need to submit all CAHPS results to NCQA? Do the requirements mean we need to do multiple locked results files to account for each sample above?**

Per CMS, for the purpose of mandatory Adult and Child Core Sets reporting, states or health plans are not required to submit results to NCQA. CAHPS data can be submitted to the AHRQ CAHPS Health Plan Survey Database. Additionally, for Child Medicaid and CHIP, health plans or states that include the CCC Supplemental Items can draw a sample of children in the general population as well as a supplemental sample of children identified through a claims-based algorithm as being likely to have a chronic condition. The survey instrument includes a screener to identify children with a chronic condition. For more information on how to submit data to the CAHPS Database, please see AHRQ's website: <https://www.ahrq.gov/cahps/cahps-database/hp-database/participate.html>.

If you have questions on CAHPS administration as part of your NCQA health plan accreditation requirements, please reach out to NCQA.

**Where can HMOs get technical assistance?**

To ensure that HMOs are compliant with Core Sets reporting requirements for the CAHPS measures, HMOs and vendors can review the Adult and Child Core Set technical specifications as well as the AHRQ Health Plan CAHPS Survey Database reporting guidance. Reporting the Adult CAHPS survey (for Adult Medicaid) and the Child Medicaid survey Including Medicaid and Children with Chronic Conditions Supplemental Items (for Child Medicaid and separate CHIP) to the AHRQ CAHPS Database will satisfy the requirements for Core Sets reporting. The AHRQ CAHPS Database will be open in June 2026 for reporting. If HMOs and vendors have specific questions regarding compliance with the AHRQ CAHPS Database (such as data file requirements), you may reach out to the CAHPS Database TA team at [CAHPSDatabase@Westat.com](mailto:CAHPSDatabase@Westat.com).

**If our HMO can't comply with all of the CAHPS requirements, what should we do?**

Send an email describing which parts you're able to complete on time and which parts you'll not be compliant with to [DHSDMSHMO@dhs.wisconsin.gov](mailto:DHSDMSHMO@dhs.wisconsin.gov), with a CC to your managed care analyst.

## IX. OB Medical Home

The HMO contract requires HMOs serving Milwaukee, Kenosha, Ozaukee, Racine, Washington, Waukesha, Dane, and Rock Counties to implement Obstetric Medical Home (OBMH) care models. This initiative 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 an OBMH User Guide and 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](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, upon request.

### EQRO Review

- The focus of the EQRO OBMH Review process is to ensure HMO and clinic compliance with OBMH requirements defined in the BC+ and Medicaid SSI HMO contract and User Guide.
- On a quarterly basis, the EQRO identifies members enrolled in the OBMH with delivery dates occurring three to six months prior to the review occurring. 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>

### Incentive Payments

- DHS will pay an incentive of \$2,000 per enrolled OBMH member who met eligibility requirements, had a healthy birth outcome, **and** absence of maternal mortality. Incentive eligibility requirements are outlined in the OBMH User Guide. See the OBMH User Guide for eligibility requirements and definition of healthy birth outcome and maternal mortality.
- Incentive payment determination is based on the EQRO's medical record review, which is completed quarterly. See the OBMH User Guide for the review schedule.
- DHS makes one payment to the HMO quarterly for the full incentive amount earned, and the HMO distributes the appropriate amount to their OBMH providers.

HMOs may contact [DHSOBMH@wi.gov](mailto:DHSOBMH@wi.gov) with questions on the OBMH requirements.

## Appendix A: Overview of Quality Initiatives Timing

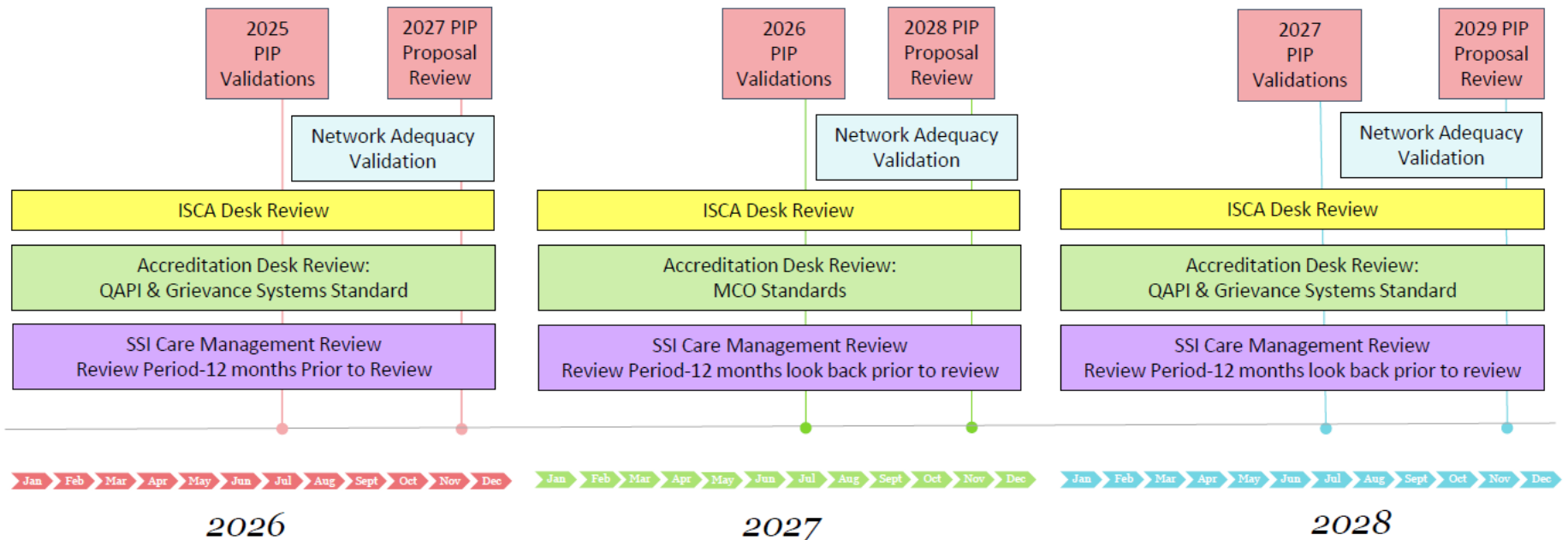
The purpose of this chart is to give an overview of due dates for the year for each initiative. For exact due dates, please review the individual section of the Quality Guide for the initiative or Appendix C.

Timelines for 2026 Quality Initiatives	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
<b>WIQR</b>												
HMO audited review tables (ARTs) of MY 2025 data to DMS												
Fee-For-Service (FFS) Supplemental Data Extract Request for MY 2026												
<b>P4P</b>												
HMO audited review tables (ARTs) of MY 2025 data to DMS												
Preliminary results from DMS												
HMO validation of results												
Final results from DMS												
<b>Report Card</b>												
HMO audited review tables (ARTs) of MY 2025 data to DMS												
DMS calculates star ratings and shares with HMOs												
DMS publishes MY 2025 report card												
<b>PPR</b>												
Preliminary results												
Final results												
<b>PIP</b>												
MY 2025 HMO final reports due												
MY 2027 HMO proposals due												
<b>CAHPS</b>												
HMOs submit results to AHRQ												

## Appendix B: 3 Year EQRO Review

### 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.
- HMOs will have Information System Capabilities Assessment (ISCA) review each year. Metastar will request HMOs submit their NCQA HEDIS Final Audit Results (FAR) to validate the ISCA.



## Appendix C: Deliverables Due Dates & Submission Instructions

Frequency	Report/Deliverable	Due Date	Template
Performance Improvement Project (PIP) Final Project Report	<ul style="list-style-type: none"> <li>Email to <a href="mailto:DHSDMSHMO@dhs.wisconsin.gov">DHSDMSHMO@dhs.wisconsin.gov</a> and EQRO contact by password protected email attachment.</li> <li>Reports are due on the 1st business day of July for the prior calendar year's PIP.</li> </ul>	7/1/2026 for 2025 projects	Appendix H
HMO HEDIS audited review tables (ARTs) of 2025 data to DHS	<ul style="list-style-type: none"> <li>Data files and documents are to be submitted to DMS via the SFTP server.</li> <li>DHS will provide HMOs specific submission instructions by 6/30/2026.</li> </ul>	7/31/2026	
Fee-For-Service (FFS) Data Extract Request (HEDIS Supplemental File)	<ul style="list-style-type: none"> <li>HMOs must submit to DMS a file with member IDs for whom HMOs would like to receive FFS data</li> <li>DHS will email HMOs submission request instructions by 10/31/2026.</li> </ul>	11/15/2026	
Initial Performance Improvement Project (PIP) Proposal	<ul style="list-style-type: none"> <li>Submit proposal information using the online application accessed via MetaStar's portal.</li> <li>Initial proposals are due on the first business day of November for the next calendar year.</li> </ul>	11/3/2025 for 2026 projects 11/2/2026 for 2027 projects	
Quality Work Plan	<ul style="list-style-type: none"> <li>Email to <a href="mailto:DHSDMSHMO@dhs.wisconsin.gov">DHSDMSHMO@dhs.wisconsin.gov</a></li> </ul>	4 <sup>th</sup> Monday in January 2026	No template requirement, HMOs may use same format as NCQA submission
Annual Evaluation of the overall effectiveness of QAPI program	<ul style="list-style-type: none"> <li>Email evaluation of the Quality Workplan to <a href="mailto:DHSDMSHMO@dhs.wisconsin.gov">DHSDMSHMO@dhs.wisconsin.gov</a></li> </ul>	7/1/2026 for 2025 evaluations 7/15/2027 for 2026 evaluations	
SSI Care Management	N/A		
PPR	N/A		
CAHPS	<ol style="list-style-type: none"> <li>To AHRQ: Annually during AHRQ's June submission period</li> <li>To DMS: Submit a copy of the CAHPS Final Results Report and Deidentified Member File via email to <a href="mailto:DHSDMSHMO@dhs.wisconsin.gov">DHSDMSHMO@dhs.wisconsin.gov</a></li> </ol>	6/30/2026	

## Appendix D: Table of Measures - WIQR, P4P, and Report Card

This list of measures is a projection based on MY 2024 IDSS template and known NCQA changes for MY 2025 at the time of Quality Guide publication. Due to the IDSS publication time lag, HMOs should review MY 2026 IDSS template when published by NCQA for final list of required measures.

For WIQR measures, all stratifications of the measure need to be reported. If only one stratification of a measure is applicable for P4P or Report Card, that stratification is noted in the table below.

DHS intends to publish the report cards using the HEDIS measures and stratifications designated for each area of care as indicated in the below table. If DMS needs to change this list (such as to replace a measure due to NCQA changes or insufficient data, or to add a measure based on clinical priority), HMOs will be informed of any changes during the development of the 2026 HMO report card (anticipated in the fall of 2027).

Measure Acronym	Measure Name	WIQR		P4P		Report Card	
		BC+	SSI	BC+	SSI	BC+	SSI
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	✓	✓				
AAF-E	Follow-Up After Acute and Urgent Care Visits for Asthma	✓	✓				
AAP	Adults' Access to Preventive/Ambulatory Health Services	✓	✓				
ADD-E	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	✓					
AHU	Acute Hospital Utilization	✓	✓				
AIS-E	Adult Immunization Status	✓	✓				
APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓				Total	
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓				Total	
ASF-E	Unhealthy Alcohol Use Screening and Follow-Up-ECDS	✓	✓				
AXR	Antibiotic Utilization for Respiratory Conditions	✓	✓				
BCS-E	Breast Cancer Screening	✓	✓		Total	Total	Total

BPC-E	Blood pressure control for Patients with Hypertension	✓	✓				
BPD *BPD-E	Blood Pressure Control for Patients with Diabetes	✓	✓				
CBP	Controlling High Blood Pressure	✓	✓	✓		✓	✓
CCS-E	Cervical Cancer Screening	✓	✓		✓	✓	✓
CHL	Chlamydia Screening	✓	✓			Total	Total
CIS-E	Childhood Immunization Status	✓		Combo 3		Combo 3	
COL-E	Colorectal Cancer Screening	✓	✓	Total		Total	Total
COU	Risk of Continued Opioid Use	✓	✓				
CRE	Cardiac Rehabilitation	✓	✓				
CWP	Appropriate Testing for Pharyngitis	✓	✓				
DBM-E	Documented Assessment After Mammogram	✓	✓				
DDM	Disability Description of Membership	✓	✓				
DMH	Diagnosed Mental Health Disorders	✓	✓				
DMS-E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	✓	✓				
DRR-E	Depression Remission or Response for Adolescents and Adults	✓	✓				
DSF-E	Depression Screening and Follow-Up for Adolescents and Adults	✓	✓				
DSU	Diagnosed Substance Use Disorders	✓	✓				
EED	Eye Exam for Patients with Diabetes	✓	✓				
ENP	Enrollment by Product Line	✓	✓				
FMA-E	Follow-Up After Abnormal Mammogram Assessment	✓	✓				
FUA	Follow-Up After ED Visit for Substance Use	✓	✓			Total, 30 day	Total, 30 day
FUH	Follow-Up After Hospitalization for Mental Illness	✓	✓	Total, 30 days	Total, 30 days	Total, 30 day	Total, 30 day
FUI	Follow-Up After High Intensity Care for Substance Use Disorder	✓	✓				
FUM	Follow-Up After Emergency Department Visit for Mental Illness	✓	✓		Total, 30 days	Total, 30 day	Total, 30 day
GSD	Glycemic Status Assessment for Patients with Diabetes (Formerly known as HBD)	✓	✓	Control <8%	Control <8%	Control <8%	Control <8%
HDO	Use of Opioids at High Dosage	✓	✓				

IET	Initiation and Engagement of Substance Use Disorder Treatment	✓	✓			Engagement Total ages (Total)	Engagement Total ages (Total)
IMA-E	Immunizations for Adolescents	✓		Combo 2		Combo 2	
KED	Kidney Health Evaluation for Patients with Diabetes	✓	✓				
LBP	Use of Imaging Studies for Low Back Pain	✓	✓				
LDM	Language Diversity of Membership	✓	✓				
LSC-E	Lead Screening in Children	✓		✓		✓	
OED	Oral Evaluation, Dental Services	✓	✓				
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	✓	✓				
PCE	Pharmacotherapy Management of COPD Exacerbation	✓	✓				
PCR	Plan All-Cause Readmissions	✓	✓			Observed / Expected (Total, 18-64)	Observed / Expected (Total, 18-64)
PDS-E	Postpartum Depression Screening and Follow-Up	✓	✓				
PND-E	Prenatal Depression Screening and Follow-Up	✓	✓				
POD	Pharmacotherapy for Opioid Use Disorder	✓	✓				
PPC	Prenatal and Postpartum Care	✓	✓	✓		✓	
PRS-E	Prenatal Immunization Status	✓	✓				
RDM	Race/Ethnicity Diversity of Membership	✓	✓				
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	✓	✓			✓	✓
SMC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	✓	✓				
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	✓	✓				
SNS-E	Social Need Screening and Intervention	✓	✓				
SPC-E	Statin Therapy for Patients with Cardiovascular Disease	✓	✓				
SPD-E	Statin Therapy for Patients with Diabetes	✓	✓				
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder	✓	✓		✓		

	Who Are Using Antipsychotic Medications						
TFC	Topical Fluoride for Children	✓					
TSC-E	Tobacco Use Screening and Cessation Intervention	✓	✓				
UOP	Use of Opioids from Multiple Providers	✓	✓				
URI	Appropriate Treatment for Upper Respiratory Infection	✓	✓				
W30	Well-Child Visits in the First 30 Months of Life	✓				✓	
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓					
WCV	Child and Adolescent Well-Care Visits	✓		Total		Total	

\*Per NCQA, for MY2026 the ECDS version of BPD is not a required to be reported, therefore DMS will only require the admin/hybrid version of BPD and the ECDS version of the measure will be optional for HMOs to report to DMS.

## Appendix E: PIP Standards and Scoring

### PIP Standards and Scoring

Reference: Department of Health and Human Services. Centers for Medicare and Medicaid Services. (February 2023). *EQR Protocol 1. Validation of Performance Improvement Projects; A Mandatory EQR-Related Activity*. Retrieved from <https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf>.

#	Standards
1	<p><b>PIP Topic</b></p> <ul style="list-style-type: none"> <li>1.1 The PIP topic was selected through a comprehensive analysis of MCO enrollee needs, care, and services.</li> <li>1.2 The PIP topic considered performance on the CMS Child and Adult Core Set measures (if applicable).</li> <li>1.3 The selection of the PIP topic considered input from enrollees or providers who are users of, or concerned with, specific service areas.</li> <li>1.4 The PIP topic addressed care of special populations or high priority services.</li> <li>1.5 The PIP topic aligned with priority areas identified by DHS and/or CMS.</li> </ul>
2	<p><b>PIP Aim Statement</b></p> <ul style="list-style-type: none"> <li>2.1 The PIP aim statement clearly specified the improvement strategy.</li> <li>2.2 The PIP aim statement clearly specified the population for the PIP.</li> <li>2.3 The PIP aim statement clearly specified the time period for the PIP.</li> <li>2.4 The PIP aim statement was concise.</li> <li>2.5 The PIP aim statement was answerable.</li> <li>2.6 The PIP aim statement was measurable.</li> </ul>
3	<p><b>PIP Population</b></p> <ul style="list-style-type: none"> <li>3.1 The project population was clearly defined in terms of the identified PIP question.</li> <li>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.</li> </ul>
4	<p><b>Sampling Method</b></p> <ul style="list-style-type: none"> <li>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.)</li> <li>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.</li> <li>4.3 The sample contained a sufficient number of enrollees taking into account non-response.</li> </ul>

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

#	Standards
	<p>6.8 Qualitative data collection methods were well-defined and designed to collect meaningful and useful information from respondents (if applicable).</p> <p><i>Administrative Data Sources (if applicable)</i></p> <p>6.9 If inpatient data was used, the data system captured all inpatient admissions/discharges.</p> <p>6.10 If primary care data was used, primary care providers submitted encounter or utilization data for all encounters.</p> <p>6.11 If specialty care data was used, specialty care providers submitted encounter or utilization data for all encounters.</p> <p>6.12 If ancillary data was used, ancillary service providers submitted encounter or utilization data for all services provided.</p> <p>6.13 If LTSS data was used, all relevant LTSS provider services were included.</p> <p>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.</p> <p><i>Medical Record Review (if applicable)</i></p> <p>6.15 A list of data collection personnel and their relevant qualifications was provided.</p> <p>6.16 For medical record review, interrater and intra-rater reliability was described.</p> <p>6.17 For medical record review, guidelines for obtaining and recording the data were developed.</p>
7	<p><b>Data Analysis and Interpretation of PIP Results</b></p> <p>7.1 The analysis was conducted in accordance with the data analysis plan.</p> <p>7.2 The analysis included baseline and repeat measurements of project outcomes.</p> <p>7.3 The analysis assessed the statistical significance of any differences between the initial and repeat measurements.</p> <p>7.4 The analysis accounted for factors that may influence the comparability of initial and repeat measurements.</p> <p>7.5 The analysis accounted for factors that may threaten the internal or external validity of the findings.</p> <p>7.6 The PIP compared the results across multiple entities, such as different patient subgroups, provider sites, or MCOs.</p> <p>7.7 PIP results and findings were presented in a concise and easily understood manner.</p> <p>7.8 To foster continuous quality improvement, the analysis and interpretation of the PIP data included lessons learned about less-than-optimal performance.</p>

#	Standards
8	<p data-bbox="334 241 657 273"><b>Improvement Strategies</b></p> <p data-bbox="431 281 1398 426">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).</p> <p data-bbox="431 434 1398 506">8.2 The strategy was designed to address root causes or barriers identified through data analysis and quality improvement processes.</p> <p data-bbox="431 514 1271 585">8.3 The rapid-cycle PDSA approach was used to test the selected improvement strategy.</p> <p data-bbox="431 594 1222 625">8.4 The strategy was culturally and linguistically appropriate.</p> <p data-bbox="431 634 1406 779">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).</p> <p data-bbox="431 787 1411 886">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.</p>
9	<p data-bbox="334 903 857 934"><b>Significant and Sustained Improvement</b></p> <p data-bbox="431 942 1227 1014">9.1 The same methodology was used for baseline and repeat measurements.</p> <p data-bbox="431 1022 1325 1094">9.2 There was quantitative evidence of improvement in processes or outcomes of care.</p> <p data-bbox="431 1102 1390 1173">9.3 The reported improvement in performance was likely to be a result of the selected intervention.</p> <p data-bbox="431 1182 1390 1253">9.4 There is statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention.</p> <p data-bbox="431 1262 1281 1318">9.5 Sustained improvement was demonstrated through repeated measurements over time.</p>

## Appendix F: PIP Scoring Aggregate Report Example

The EQRO's level of confidence in whether the PIP followed acceptable methodology across all phases, including design, data collection, analysis, and interpretation is reported for each standard in the narrative reports. Each PIP includes a methodology validation table that lists the standards evaluated. These tables show the total number of applicable scoring elements, and the percentage met for each standard, which together determine the overall methodology rating. Since not all scoring elements apply to every project, the total number of applicable elements may vary. Elements deemed not applicable are marked as 'N/A.'

Methodology Example:

Standards	Scoring Elements	Percentage	Methodology Rating
Standard 1: PIP Topic	5/5	100.0%	High Confidence
Standard 2: PIP Aim Statement	6/6	100.0%	High Confidence
Standard 3: PIP Population	2/2	100.0%	High Confidence
Standard 4: Sampling Method*	N/A	N/A	N/A
Standard 5: PIP Variables and Performance Measures	7/7	100.0%	High Confidence
Standard 6: Data Collection Procedures	10/10	100.0%	High Confidence
Standard 7: Data Analysis and Interpretation of PIP Results	8/8	100.0%	High Confidence
Standard 8: Improvement Strategies	5/6	83.3%	Moderate Confidence
Standard 9: Significant and Sustained Improvement	1/2	50.0%	No Confidence
<b>Methodology Rating</b>	<b>44/46</b>	<b>95.7%</b>	<b>High Confidence</b>

\*The MCO did not utilize sampling for this project; this standard is not applicable.

Strengths are given for standards that scored at or above 90 percent. Weaknesses, or opportunities for improvement, are included for any standard that is below 90 percent, and any scoring element that was not met. Additional opportunities for improvement may be included for elements that are minimally compliant. Recommendations are provided for all identified weaknesses and opportunities for improvement.

Example of strengths, weakness/opportunities for improvements, and recommendations for one standard:

Assessment of Clinical PIP Methodology
<b>Standard 8: Improvement Strategies</b>
<b>Strengths:</b> The MCO detailed the effectiveness of all interventions used for the PIP.

**Assessment of Clinical PIP Methodology**

**Weaknesses/Opportunities for Improvement:** Scoring element **8.1** required the MCO to select evidence-based improvement strategies. The MCO did not identify existing evidence suggesting providing a gift card to members who attested to completing cervical cancer screening would likely lead to desired improvement in outcomes. ***This scoring element is not met.***

**Recommendations:** Ensure improvement strategies are evidence-based **(8.1)**.

## Appendix G: PIP Rating Scales

Protocol One of the CMS EQR Protocols requires the EQRO to validate the overall confidence that the PIP adhered to acceptable methodology and produced evidence of significant improvement. The rating scales outlined below will be utilized to validate these measures.

To evaluate the evidence of significant improvement and determine the rating, the EQRO will request the following data:

- For HEDIS projects, the final baseline and repeat measure rate(s).
- The raw numbers, not percentages, the HMO used to calculate the baseline and repeat measures (final measure) for each aim statement of each PIP, e.g., numerators and denominators.
- The monitoring data the HMO reviewed during the PIP that correlates with the aim statements, such as monthly administrative data.

If HMOs include this data in their final reports, a separate submission will not be needed. The EQRO will utilize the significant improvement rating scale outlined below to validate these measures.

**Methodology Rating** – The level of confidence that the PIP adhered to acceptable methodology for all phases of the design, data collection, data analysis, and interpretation of PIP results. The methodology validation for each PIP includes a table listing each standard that was evaluated for the PIP methodology. The tables indicate the total number of scoring elements and percentage of scoring elements met for each standard, which determined the methodology rating. Not all scoring elements apply to every project, which makes the total applicable elements for each project different. Scoring elements that are not applicable are identified as ‘N/A.’ The following rating scale was utilized:

- High Confidence = 90.0% - 100.0%
- Moderate Confidence = 80.0% - 89.9%
- Low Confidence = 70.0% - 79.9%
- No Confidence = <70.0%

**Significant Improvement Rating** – The level of confidence that the PIP produced evidence of significant improvement. The methodology for determining whether an improvement is statistically significant depends on whether the measure is a HEDIS® measure. For HEDIS® measures, the HEDIS® Bias Determination methodology is applied to assess significance. Using HEDIS® Bias Determinations to assess rate changes ensures that observed differences are statistically significant and not due to random variation. This method provides a consistent, standardized approach aligned with NCQA guidelines.

When a rate change falls within the established threshold for a given measure, it is considered not statistically significant. This suggests that the observed change is likely attributable to normal variation or chance, rather than a true shift in performance. Conversely, when a rate change falls outside the threshold, it is deemed statistically significant, indicating a high likelihood that the change reflects a real difference in performance. If the significant change represents an improvement, the methodology supports a high level of confidence in the

statistical validity of that improvement. Because these determinations are based on final rates, the underlying data is considered valid and reliable, further reinforcing the credibility of the findings.

For projects that did not utilize a HEDIS® measure, the significant improvement rating was determined by MetaStar through the use of a statistical test using each project's baseline and repeat measurement for the aim statement. If there are multiple aim statements, testing is completed on each aim and the lowest rating achieved is the significant improvement rating for the project. Data used by the HMO to determine baseline and repeat measurements was submitted to MetaStar for the evaluation. The following rating scale was utilized:

- High Confidence = 90.0% - 100.0%
- Moderate Confidence = 80.0% - 89.9%
- Low Confidence = 70.0% - 79.9%
- No Confidence = <70.0%

## Appendix H: PIP Template

### Performance Improvement Project (PIP)

#### MY 2025 Final Report Template

#### Instructions:

- Ensure each section addresses the elements of the standard and the DHS-DMS equity requirements. The standard elements fulfill the External Quality Review Protocol PIP requirements established by the Centers for Medicare & Medicaid Service (CMS), and the equity requirements fulfill DHS-DMS PIP requirements.
- Unless otherwise indicated, submit each standard's section in a narrative format that addresses the respective scoring elements, not merely as an item-for-item statement or checklist of each of the scoring elements.
- Areas of Understanding:
  - HMO and MCO are used interchangeably. MCO is the federal term recognized by CMS. HMO is the state term.
  - The terms 'PIP' and 'project' are used interchangeably. Both terms are used to identify the performance improvement project.
  - Standards and scoring elements are written in the language from the federal protocol.
- Reference the PIP section of the Quality Guide for additional information.
- **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 because of EQRO recommendations or changes made to facilitate project implementation.

In accordance with the applicable PIP timeline, submit each respective PIP Final Report and any supporting documents to DMS at [DHSDMSHMO@dhs.wisconsin.gov](mailto:DHSDMSHMO@dhs.wisconsin.gov) and copy Don Stanislawski at MetaStar at [dstanis@metastar.com](mailto:dstanis@metastar.com).

<b>HMO Name:</b> <a href="#">Click here to enter text.</a>	<b>Report Prepared by:</b> <a href="#">Click here to enter text.</a>	<b>Date Final Report Submitted:</b> <a href="#">Click here to enter a date.</a>
<b>Project Title:</b> <a href="#">Click here to enter text.</a>		
<b>Project Implementation Date:</b> <a href="#">Click here to enter a date.</a>		
<b>Please check the following items as applicable to this PIP report:</b>		
<b>PIP Type:</b> <input type="checkbox"/> Clinical <input type="checkbox"/> Nonclinical		
<b>Population:</b> <input type="checkbox"/> SSI <input type="checkbox"/> BC+ <input type="checkbox"/> Both SSI and BC+		
<b>PIP Duration:</b> <input type="checkbox"/> One Year <input type="checkbox"/> Two Year <input type="checkbox"/> Continuing (2 <sup>nd</sup> year of a two-year PIP)		
<b>For Two-Year PIPs Only:</b> <input type="checkbox"/> Year One Report <input type="checkbox"/> Year Two Report		
<b>Primary HMO Contact Regarding PIP:</b> <a href="#">Click here to enter text.</a>		
<b>Email:</b> <a href="#">Click here to enter text.</a>	<b>Phone:</b> <a href="#">Click here to enter text.</a>	
<b>Project Team:</b>		
<b>Name</b>	<b>Agency/Title/Department</b>	

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Click here to enter text.		Click here to enter text.
Click here to enter text.		Click here to enter text.
<b>For Continuing PIPs</b> , include a brief description of PIP progress made to date, any barriers encountered, and any benefits achieved for members.		
Click here to enter text.		
<b>STANDARD 1: PIP TOPIC</b> (Total possible score: 5)		
Elements of this Standard		Instructions
<b>1.1</b>	The PIP topic was selected through a comprehensive analysis of MCO enrollee needs, care, and services.	Describe the process or analysis used to prioritize and select this topic as an area or opportunity for improvement.  Include details of the member needs assessment that helped identify baseline performance.  Include the baseline data and the timeframe of the baseline data.  Describe the relevance of this topic to the organization’s membership.  Identify why the topic is important to members.
<b>1.2</b>	The PIP topic considered performance on the CMS Child and Adult Core Set measures (if applicable).	If applicable, address any performance on CMS Child and Adult Core Set measures considered in the selection of the topic.
<b>1.3</b>	The selection of the PIP topic considered input from enrollees or providers who are users of, or concerned with, specific service areas.	Describe all member and/or provider input obtained in considering this topic as an opportunity for improvement.
<b>1.4</b>	The PIP topic addressed care of special populations or high priority services.	Identify how the topic relates to the health and/or functional status of members (address consideration of care of special populations or high priority services, as applicable).
<b>1.5</b>	The PIP topic aligned with priority areas identified by DHS and/or CMS.	Identify how the topic aligns with a DHS and/or CMS priority.

**DHS-DMS Equity Requirements:**

- Include a clear rationale or objective(s) for selecting the PIP 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, disability, primary language, race, and/or ethnicity (encouraged to select at least two stratifications) 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.
  - Consideration of any performance measures.
- Include a description of how the HMO selected the topic, including the data used, as an area for improvement related to reducing disparities and addressing social determinant of health needs for members.
- Include how the PIP addresses underlying causes of inequities, such as intrapersonal, interpersonal, institutional, and systemic discrimination and/or policies; unequal allocation of power and resources; conscious and unconscious bias; and harmful social norms.

**Standard 1:**

**STANDARD 2: PIP AIM STATEMENT**  
 (Total possible score: 6)  
 All elements of this standard must be included in each aim statement and not obtained from elsewhere in the report.  
 Each aim statement should be written as a complete statement that incorporates all the elements.

<b>Elements of this Standard</b>		<b>Instructions</b>
<b>2.1</b>	The PIP aim statement clearly specified the improvement strategy.	Include the intervention or improvement strategies that will be implemented. This is a very brief summary of the strategies.
<b>2.2</b>	The PIP aim statement clearly specified the population for the PIP.	Identify the population that will be involved in the PIP.
<b>2.3</b>	The PIP aim statement clearly specified the time period for the PIP.	Include the start and end dates for the project.
<b>2.4</b>	The PIP aim statement was concise.	Ensure the aim is understandable and explains the project’s basic framework.

2.5	The PIP aim statement was answerable.	Ensure the aim is answerable (Yes or No answer) by including all required aim elements.
2.6	The PIP aim statement was measurable.	Identify a specific numerical goal(s) and target date(s) for each aim. Include the rate of desired improvement (from what to what).
<b>DHS-DMS Equity Requirement:</b>		
<input type="checkbox"/> The aim is focused on reducing the disparity for the target population. The target population must be the underrepresented or socially disadvantaged population. One aim statement for each project is recommended.		
<b>Standard 2:</b>		
<b>STANDARD 3: PIP POPULATION</b> (Total possible score: 2)		
<b>Elements of this Standard</b>		<b>Instructions</b>
3.1	The project population was clearly defined in terms of the identified PIP question.	Describe the relevant population (all members to whom the study question and indicators apply). Include: <ul style="list-style-type: none"> <li>Any inclusion or exclusion criteria</li> <li>Any enrollment/eligibility criteria (for example, requirements for how long members had to be enrolled).</li> </ul>
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.	If data for the entire population will be studied, describe how the data collection approach will capture all members to whom the study question applied.
<b>Standard 3:</b>		
<b>STANDARD 4: SAMPLING METHOD</b> (Total possible score: 5)		
<b>Elements of this Standard</b>		<b>Instructions</b>
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.)	Describe the sampling frame the PIP sample was drawn from.

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.	Describe a valid sampling method utilized, including the confidence interval and margin of error.
4.3	The sample contained a sufficient number of enrollees taking into account non-response.	Describe the method used to determine the sample size needed.
4.4	The method assessed the representativeness of the sample according to subgroups, such as those defined by age, geographic location, or health status.	Describe how the sampling method represented subgroups.
4.5	Valid sampling techniques were used to protect against bias.	Ensure a valid sampling method was utilized.

**Standard 4:****STANDARD 5: PIP VARIABLES AND PERFORMANCE MEASURES**

(Total possible score: 10)

Elements of this Standard		Instructions
5.1	The variables were adequate to answer the PIP question.	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 aims(s) or question(s).
5.2	The performance measure assessed an important aspect of care that will make a difference to enrollees' health or functional status.	Summarize how the performance measures assess 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.	Summarize how the performance measures are appropriate and based on the availability of resources to collect the data.
5.4	The measures were based on current clinical knowledge or health services research.	Summarize how the performance measures are 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.	Summarize how the performance measures will monitor, track, and compare performance over time; and inform 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.	If CMS Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, or AHRQ, or other existing measures are used, include the relevant specifications.
5.7	The MCO developed new measures based on current clinical practice guidelines or health services research if there were gaps in existing measures.	Summarize how the performance measures address any gaps in existing measures, if applicable.
5.8	The measures captured changes in enrollee satisfaction or experience of care.	Summarize how the measure captured changes in enrollee satisfaction or experience of care.
5.9	The measures included a strategy to ensure inter-rater reliability (if applicable).	Describe the inter-rater reliability process utilized for manual data collection, if applicable.
5.10	The process measure is meaningfully associated with outcomes (if applicable).	Identify any process measures used.
<b>Standard 5:</b>		
<b>STANDARD 6: DATA COLLECTION PROCEDURES</b> (Total possible score: 16)		
<b>Elements of this Standard</b>		<b>Instructions</b>
6.1	The PIP design specified a systematic method for collecting valid and reliable data that represents the population in the PIP.	Clearly describe the data collection components for all PIP indicators.

6.2	The PIP design specified the frequency of data collection.	Describe the frequency of data collection; how often the data collection is planned.
6.3	The PIP design clearly specified the data sources.	Identify all data sources (for example, claims/administrative data, member files).
6.4	The PIP design clearly defined the data elements to be collected.	Describe what data is being collected.
6.5	The data collection plan linked to the data analysis plan to ensure that appropriate data would be available for the PIP.	Describe how the data collection plan aligns with the data analysis plan. Describe how the data was stored and aggregated (for example, registry, database).
6.6	The data collection instruments allowed for consistent and accurate data collection over the time periods studied.	Identify data collection tools used. Include samples of any data collection tools or instruments as an attachment.
6.7	Qualitative data collection methods were well-defined and designed to collect meaningful and useful information from respondents (if applicable).	Identify any qualitative data collection methods used to collect data for the PIP aim.
<b>Administrative Data (if applicable):</b> Data generated through the routine administration of Health Care Programs. This refers to information that is collected, processed, and stored in automated information systems. Data obtained from the MCO's electronic care management system is considered administrative data.		
6.8	If inpatient data will be used, the data system captures all inpatient admissions/discharges	Describe the inpatient data that was used and identify how all inpatient admissions/discharges were captured
6.9	If primary care data will be used, primary care providers submit encounter or utilization data for all encounters	Describe the data obtained from primary care providers (typically billing/claims for services), and how it was captured
6.10	If specialty care data will be used, specialty care providers submit encounter or utilization data for all encounters	Describe the data obtained from specialty care providers and how it was captured. Examples of specialty care providers include podiatrists, nephrologists, oncologists, orthopedics, etc.
6.11	If ancillary data will be used, ancillary service providers submit encounter or utilization data for all services provided	Describe the ancillary service data used and how it was captured. Ancillary services are medical services or supplies that are not provided by acute care hospitals, doctors, or health care professionals (typically billing/claims for services).

6.12	If LTSS data will be used, all relevant LTSS provider services are included	Identify the LTSS data used and how it was captured. Includes all acceptable services outlined in waiver services. (This data would only be in Family Care, PACE, and Family Care Partnership projects.)
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	The MCO's electronic care management systems are electronic health records (EHRs), and if the MCO is collecting data from their own EHR, then they would need to describe how that is done, and if there is an over-read or internal quality control (IQC) process in place to validate the data being collected.
<b>Medical Record Review Data (if applicable):</b> Medical record review/abstraction process is when the MCO requests or accesses medical records of their members from external medical providers, such as clinics, hospitals, and other health care providers.		
6.14	A list of data collection personnel and their relevant qualifications is provided.	Provide a list of data collection personnel and their relevant qualifications
6.15	For medical record review, interrater and intra-rater reliability is described.	Describe the method to assure interrater and intra-rater reliability
6.16	For medical record review, guidelines for obtaining and recording the data were developed.	Describe the guidelines for obtaining and recording data or identify the HEDIS Hybrid specifications utilized.
<p><b>DHS-DMS Equity Requirements:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ensure data collection plan includes collecting data from comparative groups, including overall HMO population rates (i.e. overall HEDIS rates).</li> <li><input type="checkbox"/> Include how the PIP empowers member voice, such as being designed with member participation or input, planned collection of member feedback, or measurement of member satisfaction.</li> <li><input type="checkbox"/> Include in the report how the PIP design, data collection, and data analysis are guided by ethical considerations and respect for members (e.g., valuing members' culture, time, and feedback).</li> </ul>		
<b>Standard 6:</b>		

<b>STANDARD 7: DATA ANALYSIS AND INTERPRETATION OF PIP RESULTS</b>		
(Total possible score: 8)		
This standard is specific to the data analysis and interpretation of results for the aim statements.		
<b>Elements of this Standard</b>		<b>Instructions</b>
<b>7.1</b>	The analysis was conducted in accordance with the data analysis plan.	Describe how the data analysis was conducted and aligned with the data analysis plan.
<b>7.2</b>	The analysis included baseline and repeat measurements of project outcomes.	Identify the baseline and repeat measurements of the project outcomes.
<b>7.3</b>	The analysis assessed the statistical significance of any differences between the initial and repeat measurements.	Identify the statistical testing method used to assess differences between the initial and repeat measurements and describe the findings from the statistical testing that was completed. This includes improvements and declines in the results.
<b>7.4</b>	The analysis accounted for factors that may influence the comparability of initial and repeat measurements.	Identify any factors that may influence the comparability of initial and repeat measurements. This includes details on any changes made during the project that impacted the baseline rate, population, etc.
<b>7.5</b>	The analysis accounted for factors that may threaten the internal or external validity of the findings.	Discuss any factors that may threaten the internal or external validity of the findings.
<b>7.6</b>	The PIP compared the results across multiple entities, such as different patient subgroups, provider sites, or MCOs.	Discuss comparison of the results across multiple entities, such as different member subgroups, provider sites, or MCOs.
<b>7.7</b>	PIP results and findings were presented in a concise and easily understood manner.	Present results accurately and clearly. Include any applicable tables, charts, and/or graphs.
<b>7.8</b>	To foster continuous quality improvement, the analysis and interpretation of the PIP data included lessons learned about less-than-optimal performance.	Identify and discuss any lessons learned about less-than-optimal performance.
<b>Standard 7:</b>		

<b>STANDARD 8: IMPROVEMENT STRATEGIES</b>		
(Total possible score: 6)		
<b>Elements of this Standard</b>	<b>Instructions</b>	
<b>8.1</b>	<p>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).</p>	<p>Describe how the improvement strategy was selected with respect to available evidence from the literature, data, root cause analysis, or barrier analysis.</p> <p>Explain how the improvement strategy was determined to be likely to lead to the desired improvement in processes or outcomes.</p>
<b>8.2</b>	<p>The strategy was designed to address root causes or barriers identified through data analysis and quality improvement processes.</p>	<p>Discuss how the improvement strategy was designed to address root causes or barriers identified through data analysis and quality improvement processes.</p>
<b>8.3</b>	<p>The rapid-cycle PDSA approach was used to test the selected improvement strategy.</p>	<p>Include how the Plan-Do-Study-Act (PDSA) approach was utilized.</p>
<b>8.4</b>	<p>The strategy was culturally and linguistically appropriate.</p>	<p>Discuss how the improvement strategy was culturally and linguistically appropriate. This element is always applicable, even for non-member facing improvement strategies.</p>
<b>8.5</b>	<p>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).</p>	<p>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 (for example, member risk factors, Medicaid program changes, provider education, clinic policies or practices).</p>
<b>8.6</b>	<p>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.</p>	<p>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.</p>

**DHS-DMS Equity Requirements:**

- Include how the improvement strategy identified gaps related to disparities and social determinants of health (SDoH) and be prepared to discuss how the proposal is likely to succeed in reducing inequities.
- Include how the improvement strategy selected to address the identified disparity will be sustainable, replicable, and/or scalable after the duration of the PIP project.
- Ensure the improvement strategy is going beyond basic, administrative activities (e.g., reminder calls or postcards).
- Include how HMO members, community-based organizations, and/or community-level practitioners were consulted in designing the improvement strategies.
- Include how the design accounts for members’ cultural backgrounds, values, religions, languages, etc.

**Considerations when working with community-based organizations (CBOs):**

HMOs should consider how new and ongoing partnerships with CBOs can help HMOs design and implement PIPs that are successful at reducing disparities identified in the PIP target population. HMOs should include a description of the role the CBO has in the PIP. Suggested considerations include:

- How the CBO addresses a social determinant need relevant to the target PIP population and aim.
- How the CBO contributes to culturally and linguistically appropriate service provision; for example, assisting with focus groups designed to gather member feedback or providing training to HMO and provider staff.

**Standard 8:**

**STANDARD 9: SIGNIFICANT AND SUSTAINED IMPROVEMENT**

(Total possible score: 4 (New PIPs); 5 (Continuing PIPs))

Elements of this Standard		Instructions
9.1	The same methodology was used for baseline and repeat measurements.	Clearly describe how the same methodology was used for baseline and repeat measurements for each aim statement.
9.2	There was quantitative evidence of improvement in processes or outcomes of care.	Specify the quantitative evidence of improvement in processes or outcomes of care for each aim statement.
9.3	The reported improvement in performance was likely to be a result of the selected intervention.	Discuss the extent to which reported improvement in performance was likely to be a result of the selected intervention(s) for each aim statement.

9.4	There is statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention.	Identify the statistical testing method used to assess if the improvement between the initial and repeat measurements was statistically significant, and likely to be attributed to the interventions, and describe the findings from the statistical testing that was completed. Include this information for each aim statement.
9.5	Sustained improvement was demonstrated through repeated measurements over time.	If applicable, identify any sustained improvement demonstrated through repeated measurements over time.
<b>Standard 9:</b>		

**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)**

## Appendix I: SSI-CM EQRO Scoring Tool

Section 1: Screening			
1.1 The screen was completed within the required timeframe			
Scoring Options	Reasons for Not Met	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met	<p>a) The screen was not completed within 60 days of the member’s enrollment</p> <ul style="list-style-type: none"> <li>i. Contact attempt(s) made</li> <li>ii. No contact attempt(s) made</li> </ul> <p>b) The screen was not completed within 60 days of the member’s re-enrollment</p> <ul style="list-style-type: none"> <li>i. Contact attempt(s) made</li> <li>ii. No contact attempt(s) made</li> </ul> <p>c) The screen was not completed once every 12 months</p> <ul style="list-style-type: none"> <li>i. Contact attempt(s) made</li> <li>ii. No contact attempt(s) made</li> </ul>	<p>The screening must be completed within 60 calendar days of the member’s enrollment, and at least once every twelve months thereafter.</p> <p>Screening must occur within 60 calendar days of re-enrollment if re-enrollment is six months or greater from the disenrollment date.</p> <p>CY 26 Changes: Added screening contact attempts tracking.</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.3.a.ii</p> <p><i>The screening must be completed by the HMO within 60 days of the member’s HMO enrollment.</i></p> <p><i>Members that were previously enrolled in the HMO but had a disenrollment period of six months or more from their last disenrollment must also have a screening within 60 days of the member’s re-enrollment in the HMO.</i></p> <p><i>The screening must be completed by the HMO no later than the end of the twelfth month from the date of the most recent screen. For example, if the HMO completes a screen on May 2 of year one, then the HMO must complete another screen by May 31 of year two.</i></p>

	<p>d) The screen was completed more than 12 months apart</p> <ul style="list-style-type: none"> <li>i. Contact attempt(s) made</li> <li>ii. No contact attempt(s) made</li> </ul> <p>e) A screen was developed, but the member was not involved with the screen</p>		
<b>1.2 The screen included all required elements</b>			
Scoring Options	Reasons for Not Met	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A	<p>The screen did not include an evaluation of:</p> <ul style="list-style-type: none"> <li>a) Physical health</li> <li>b) Behavioral health</li> <li>c) Perception of strengths and well-being</li> <li>d) Usual source of care</li> <li>e) Indirect supports</li> <li>f) Community resources/relationships</li> </ul>	<p>The screening must include all required components.</p> <p>Applies only to records with a completed screen.</p> <p>CY 26 Changes: None</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.3.a.iv.a-g</p> <p><i>At a minimum, the screening must include questions that enable the HMO to identify the following:</i></p> <ul style="list-style-type: none"> <li>a) <i>The member’s chronic physical, mental and behavioral health illness(es) (e.g. respiratory disease, cardiac disease, stroke, diabetes/pre-diabetes, renal disease, back pain and musculoskeletal disorders, cancer, overweight/obesity, all mental health and substance abuse disorders).</i></li> </ul>

	<p>g) SDOH</p> <p>h) ADL</p> <p>i) IADL</p>		<p><i>b) The member’s perception of their strengths, their general well-being (including chronic conditions and access to prescription medications).</i></p> <p><i>c) If the member has a usual source of care.</i></p> <p><i>d) Any indirect supports the member may have (family and social supports).</i></p> <p><i>e) Any relationships the member may have with community resources.</i></p> <p><i>f) Any immediate and/or long-term concerns a member may have about their overall well-being (e.g. social determinants of health).</i></p> <p><i>g) If the member needs assistance to conduct activities of daily living (including but not limited to bathing, dressing and eating) as well as instrumental activities of daily living (including but not limited to medication management, money management and transportation).</i></p>
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Section 2: Care Planning			
2.1 The care plan was completed within the required timeframe			
Scoring Options	Reasons for Not Met	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met	<p>a) The care plan was not completed for new or re-enrolled members within 30 days of completion of the screening or 90 days after enrollment, whichever comes first</p> <ul style="list-style-type: none"> <li>i. Contact attempt(s) made</li> <li>ii. No contact attempt(s) made</li> </ul> <p>b) The care plan was not completed for current members within 30 days of completion of the screening</p> <ul style="list-style-type: none"> <li>i. Contact attempt(s) made</li> <li>ii. No contact attempt(s) made</li> </ul> <p>c) The care plan was completed more than 30 days of completion of the screening</p> <ul style="list-style-type: none"> <li>i. Contact attempt(s) made</li> </ul>	<p>The care plan must be completed within 30 calendar days of the completed screening or 90 calendar days after enrollment, whichever comes first.</p> <p>CY 26 Changes: Added care plan contact attempt tracking.</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.3.e.ii.a-b</p> <p>The Comprehensive Care Plan must be completed within 30 days of completion of the Screening or 90 days after enrollment in the HMO, whichever comes first for new and re-enrolled members.</p> <p>All currently enrolled members must have a Comprehensive Care Plan completed by the HMO within 30 days of completion of the annual. screen</p>

	<p>ii. No contact attempt(s) made</p> <p>d) A care plan was developed, but the member was not involved with the care plan development</p>		
<b>2.2 The care plan included all required elements</b>			
Scoring Options	Reasons for Not Met	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A	<p>The care plan did not include:</p> <p>a) Member-centric goals</p> <p>b) Interventions for each goal</p> <p>c) Sequenced interventions</p> <p>d) The member’s readiness to self-manage/adopt healthy behaviors</p> <p>e) Health literacy and cultural competency</p> <p>f) Informal or formal supports</p>	<p>The care plan must include the contract required characteristics.</p> <p>Applies only to records with a completed care plan.</p> <p>CY 26 Changes: None</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.3.e.iv.a-f</p> <p>BC+/SSI-DHS 2025 Contract, Article III.C.3.f.i.a-c</p> <p><i>The Comprehensive Care Plan must have the following characteristics:</i></p> <p><i>a) Be member-centric, incorporating the member’s short and long-term health and well-being goals.</i></p> <p><i>b) Incorporate health literacy and cultural competency attributes based on the individual member needs.</i></p> <p><i>c) Reflect understanding between the member and the care management team or WICT.</i></p>

	<ul style="list-style-type: none"> <li>g) Physical health, chronic conditions and acute illnesses</li> <li>h) Mental and behavioral health conditions</li> <li>i) Dental</li> <li>j) Medications</li> <li>k) ADL supports/providers</li> <li>l) IADL supports/providers</li> <li>m) SDOH</li> <li>n) Other factors that will impact the member's ability to achieve goals</li> <li>o) Assessed gaps in care</li> </ul>		<ul style="list-style-type: none"> <li>d) <i>Identify all formal and informal supports, by name or position, that are instrumental to the member's care plan goals (e.g. family, friends, caregivers, providers, community agencies). Include their role in executing the care plan, and if/how they will receive care plan updates.</i></li> <li>e) <i>Identify the member's current medical and non-medical needs to be addressed by the care management team or WICT including:</i> <ul style="list-style-type: none"> <li>a. <i>Chronic conditions and acute illnesses;</i></li> <li>b. <i>Mental and behavioral health conditions and history of abuse, violence, or traumatic life events;</i></li> <li>c. <i>Dental care needs;</i></li> <li>d. <i>Medications taken by the member;</i></li> <li>e. <i>Additional supports to conduct activities</i></li> </ul> </li> </ul>
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			<p><i>of daily living (including but not limited to bathing, dressing, and eating) and instrumental activities of daily living (including but not limited to medication management, money management, and transportation);</i></p> <p><i>f. Social determinants of health;</i></p> <p><i>g. Other factors that will impact the member's ability to achieve goals.</i></p> <p><i>f) Identify and address any gaps in care ensuring that the member has a primary care provider, and behavioral health specialist, dentist, or other health specialists as needed.</i></p> <p><i>As part of the Comprehensive Care Plan development, the care management team or the WICT, in coordination with the member,</i></p>
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			<p><i>must create an evidence-based plan of care that includes:</i></p> <ul style="list-style-type: none"> <li><i>a) Specific goals appropriate for the member’s needs,</i></li> <li><i>b) The member’s readiness to self-manage their care and their willingness to adopt healthy behaviors,</i></li> <li><i>c) A description of the interventions that will be implemented to address the member’s needs and their sequence.</i></li> </ul>
<b>2.3 The care plan was shared with all required team members</b>			
<b>Scoring Options</b>	<b>Reasons for Not Met</b>	<b>Guidance</b>	<b>Source</b>
<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A	<ul style="list-style-type: none"> <li>a) The care plan was not shared with the member</li> <li>b) The care plan was not shared with the identified PCP</li> <li>c) A PCP was not identified; therefore, the care plan was not shared with the PCP</li> <li>d) The care plan was not shared others as identified in the plan</li> </ul>	<p>The care plan must be shared with all required team members. If the member refuses to share the care plan with the PCP, this should be documented in the record.</p> <p>HMOs must ensure members are linked to a primary care provider or primary care clinic, and with member approval, share the care plan with that provider.</p> <p>Applies only to records with a completed care plan.</p> <p>CY 26 Changes: None</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.3.f.ii.b.1-3</p> <p><i>Upon completion, share the Comprehensive Care Plan with:</i></p> <ul style="list-style-type: none"> <li><i>a) the member;</i></li> <li><i>b) the member’s primary care provider, with member approval;</i></li> <li><i>c) and others identified in the care plan and discussed with member.</i></li> </ul>

<b>2.4 The member or authorized representative agreed to the care plan prior to its implementation</b>			
Scoring Options	Reasons for Not Met	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A	a) The member did not agree to the care plan b) The authorized representative did not agree to the care plan	<p>The member must agree with the care plan prior to its implementation.</p> <p>If the member’s legal guardian, activated power of attorney, and/or authorized representative may agree to the member’s care plan. Documented consent must be found in the record.</p> <p>Applies only to records with a competed care plan.</p> <p>CY 26 Changes: Added Not Met rationale to better distinguish between member agreement and authorized representative agreement.</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.3.f.ii.a</p> <p>BC+/SSI-DHS 2025 Contract, Article I.A.11</p> <p><i>The care management team or the WICT must obtain the member’s agreement prior to its implementation.</i></p> <p><i>An individual appointed by the member, including a power of attorney or estate representative, who may act on the member’s behalf under certain circumstances with documented consent of the member. The role of the authorized representative primarily includes filing a grievance or appeal, and approving the member’s care plan.</i></p>
<b>2.5 The care plan was reviewed at least once every 12 months</b>			
Scoring Options	Reasons for Not Met	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A	a) The previous care plan was not found b) The current care plan was not found <ol style="list-style-type: none"> <li>i. Contact attempt(s) made</li> </ol>	<p>The care plan must be reviewed at least once every 12 months.</p> <p>Applies only to records with a competed care plan.</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.3.g</p> <p><i>At a minimum, all SSI Managed Care members must be contacted once every 12 months (by either the care management team or the</i></p>

	<ul style="list-style-type: none"> <li>ii. No contact attempt(s) made</li> <li>c) The care plan review was greater than 12 months apart <ul style="list-style-type: none"> <li>i. Contact attempt(s) made</li> <li>ii. No contact attempt(s) made</li> </ul> </li> <li>d) A care plan was developed, but the member was not involved with the care plan development</li> </ul>	<p>CY 26 Changes: Added care plan review contact attempts tracking. Moved this indicator to Care Planning section.</p>	<p><i>WICT) to review the Comprehensive Care Plan, or more frequently based on the member's needs.</i></p>
<b>2.6 The care plan was updated for changing member needs</b>			
Scoring Options	Outcome	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A	<ul style="list-style-type: none"> <li>a) Care plan was updated</li> <li>b) Care plan was not updated, contact attempt(s) made</li> <li>c) Care plan was not updated, no contact attempt(s) made</li> </ul>	<p>The care plan must be updated when member changing needs are identified. Changing needs include significant changes to medical and/or behavioral health, member non-responsiveness to treatment plan, frequent transitions between care settings, at the member's request, and/or the care management team's identification of a problem or gap in member care.</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.3.g.ii.a-d</p> <p><i>The Comprehensive Care Plan must be updated, in any of the following scenarios:</i></p> <ul style="list-style-type: none"> <li>a) <i>Whenever there are significant changes to the member's medical and behavioral health conditions. For example, when a member is diagnosed with a new chronic condition or experiences severe</i></li> </ul>

		<p>Applies only to records that have a completed care plan and a change in need.</p> <p>CY 26 Changes: Added care plan update contact attempts tracking. Moved indicator to Care Planning section.</p>	<p><i>complications from an existing condition that results in a hospitalization.</i></p> <p><i>b) The member is not responsive to the treatment plan outlined in the Care Plan.</i></p> <p><i>c) The member frequently transitions between care settings, e.g. members that have an Emergency Room visit or are admitted to the hospital and then are discharged to home, or members that are discharged from a hospital to a Skilled Nursing Home facility.</i></p> <p><i>d) At the member’s request or whenever the care management team or the WICT identifies a problem or a gap in the member’s care. This would include social determinants such as becoming homeless or experiencing food instability.</i></p> <p><i>The member must approve all updates made to the Comprehensive Care Plan and</i></p>
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			<i>member consent must be captured in the updated Comprehensive Care Plan</i>
<b>Section 3: Care Coordination</b>			
<b>3.1 The care management team contacted the member once every 12 months or more frequently based on the member's stratification level</b>			
Scoring Options	Reasons for Not Met	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A	<p>a) The care management team did not attempt to contact the member at least once every 12 months</p> <p>b) The care management team did not attempt to contact the member based on the assigned stratification level</p> <p>c) The care management team attempted to contact the member based on the assigned stratification level; however, the member was not reached</p> <p>d) The care management team did not stratify the member for all months of enrollment; therefore,</p>	<p>The member must be contacted at the specified frequency based on the member's stratification level. At minimum, the member must be contacted at least once every 12 months.</p> <p>Applies only to records where the member's enrollment is equal to or great to the member's stratification during the review period.</p> <p>CY 26 Changes: None</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.3.d.i-vii</p> <p>BC+/SSI-DHS 2025 Contract, Article III.C.3.g</p> <p><i>Needs stratification aims to align the member's overall medical and social needs with the most appropriate level of care management for that member, including WICT for highest needs members.</i></p> <p><i>The HMO must have established processes, systems, tools, models, and administrative and clinical staff to conduct the following tasks related to needs stratification:</i></p> <p><i>a) Proactively stratify individual members upon enrollment, using clinical, social, administrative and other relevant data collected during information</i></p>

	contact requirements cannot be validated.		<p><i>Gathering of the care management process.</i></p> <p><i>At a minimum, all SSI Managed Care members must be contacted once every 12 months to review the Comprehensive Care Plan, or more frequently based on the member's needs.</i></p>
<b>3.2 The member's stratification was reassessed after a critical event</b>			
Scoring Options	Outcome	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A	a) Reassessment occurred b) Reassessment did not occur	<p>The care management team reassessed the member's stratification level after a critical event.</p> <p>Applies only to records where a critical event occurs.</p> <p>CY 26 Changes: Moved indicator to Care Coordination section.</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.3.d.v</p> <p><i>Periodically reassess whether the members are assigned to the most appropriate strata, based on changes in their overall medical and social needs.</i></p>
<b>3.3 The transition care follow-up included the review of hospital discharge information with the member within the required timeframe</b>			
Scoring Options	Reasons for Not Met	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A	a) Contact with the member did not occur <ol style="list-style-type: none"> <li>i. Contact attempt(s) made</li> <li>ii. No contact attempt(s) made</li> </ol>	<p>The member must be contacted within five business days of discharge from an inpatient hospital facility.</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.3.h..i.a-b</p> <p><i>The care management team or WICT must have follow-up contact with the member and his/her family supports within five business days</i></p>

	<p>b) Contact with the member occurred more than five business days of discharge</p> <ul style="list-style-type: none"> <li>i. Contact attempt(s) made</li> <li>ii. No contact attempt(s) made</li> </ul> <p>c) Discharge follow-up did not include:</p> <ul style="list-style-type: none"> <li>i. Medication list review and reconciliation</li> <li>ii. Evaluation of the member’s ability to manage their medications</li> <li>iii. Helping the member understand their treatment plan</li> <li>iv. Helping the member understand their medication schedule</li> <li>v. Helping the member understand how to best manage their conditions</li> </ul>	<p>Upon hospital discharge, follow-up must occur with the member. The follow-up must include a review and reconciliation of the member’s medication list, an evaluation of the member’s ability to manage their medications, helping the member understand their treatment plan, helping the member understand their medication and medication schedule, and help the member understand how to best manage their conditions.</p> <p>Applies only to records where a hospitalization occurred.</p> <p>CY 26 Changes: Combined indicators 5.1 and 5.2 to avoid duplicative measurements. Added tracking of hospital discharge contact tracking. Moved indicator to Care Coordination section.</p>	<p><i>of discharge from an inpatient hospital facility.</i></p> <p><i>The follow-up must include reviewing the discharge information prepared by the hospital with the member, conducting medication list review and reconciliation, including a comparison of medications prescribed vs taken by member, an evaluation of the member’s ability to set up, administer, and monitor their own medication and helping the member understand:</i></p> <ul style="list-style-type: none"> <li><i>a) Their treatment plan.</i></li> <li><i>b) Their medications and medication schedule.</i></li> <li><i>c) How to best manage their conditions.</i></li> </ul>
<p><b>3.4 The care management team addressed and provided timely follow-up of the member’s needs</b></p>			
<p>Scoring Options</p>	<p>Outcome</p>	<p>Guidance</p>	<p>Source</p>
<p><input type="checkbox"/>Met <input type="checkbox"/>Not Met <input type="checkbox"/>N/A</p>	<p>a) Follow-up was timely b) Follow-up was not timely, contact attempt(s) made</p>	<p>The care management team must address and provide timely follow-</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.1.a-e</p>

	<p>c) Follow-up was not timely, no contact attempt(s) made</p> <p>d) No follow-up was identified, contact attempt(s) made</p> <p>e) No follow-up was identified, no contact attempt(s) made</p>	<p>up for all identified member needs and requests.</p> <p>Applies only to records that have a follow-up need or request occur.</p> <p>CY 26 Changes: Added follow-up contact tracking.</p>	<p><i>The HMO care model(s) must have the following characteristics:</i></p> <p><i>Effective Member Outreach and Engagement. HMOs must develop effective outreach strategies to connect with and engage SSI members using a member-centric, culturally competent, collaborative approach to care. The HMO must encourage member self-determination and self-care.</i></p> <p><i>A Coordinated, Team-based, Patient-centered Approach to Care. The care management model must include shared decision-making between the care management team and members; scheduling flexibility; and team-based, care coordination services.</i></p> <p><i>Social Determinants Approach to Care. The HMO must establish partnerships and maintain effective working relationships with social service and community-based agencies to ensure the social determinants of health (e.g., housing instability, low health literacy, chronic stress, traumatic</i></p>
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			<p><i>life events, and other social factors) are identified and addressed.</i></p> <p><i>Evidence Based Approach to Care. The HMO must monitor health care outcomes regularly and promote the use of evidence-based care.</i></p>
<b>Section 4: Wisconsin Interdisciplinary Care Team</b>			
<b>4.1 The WICT Core Team included at minimum two licensed health care providers</b>			
Scoring Options	Reasons for Not Met	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A	<p>a) WICT team did not include two licensed health care providers</p> <p>b) WICT team credentials could not be verified in the record</p>	<p>The WICT Core Team must comprise of two licensed health care providers.</p> <p>Applies only to records that have a WICT assignment.</p> <p>CY 26 Changes: Added reasons for not met for clarity.</p>	<p>BC+/SSI-DHS 2025 Contract, Article III.C.2.b.i</p> <p><i>The WICT will have a Core Team which must include a minimum of two licensed health care professionals with adequate expertise across medical, mental and behavioral health, and social determinants of health. The WICT Core Team must have ready access to dedicated resources such as pharmacists, physicians, psychiatrists, dieticians, rehabilitation therapists, and substance abuse specialists. These resources should be engaged as part of the WICT Core Team depending on member needs.</i></p>

4.2 The WICT Core Team met at minimum weekly to discuss the member			
Scoring Options	Reasons for Not Met	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A	<i>Details will be included in individual member reports and will track the weeks the WICT team did not convene</i>	<p>The WICT Core Team must meet at minimum weekly to discuss the member.</p> <p>Applies only to records that have a WICT assignment.</p> <p>CY 26 Changes: None</p>	<p>BC+/SSI-DHS 2025 Contract, Article IIIC.2.b.ii</p> <p><i>At a minimum, the WICT Core Team must meet weekly, preferably in-person, to discuss their entire shared case load.</i></p>
4.3 The WICT Core Team met once a month face-to-face with the member			
Scoring Options	Reasons for Not Met	Guidance	Source
<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A	<p>a) The WICT Core Team did not meet once a month face-to-face with the member</p> <ul style="list-style-type: none"> <li>i. Contact attempt(s) made</li> <li>ii. No contact attempt(s) made</li> </ul> <p>b) The WICT Core Team met monthly with the member, but the meeting was not face-to-face</p> <p>c) Community-based case manager delegation did not include:</p> <ul style="list-style-type: none"> <li>i. Documentation of close collaborative relationship with the WICT team</li> </ul>	<p>The WICT Core Team must meet once a month face-to-face with the member.</p> <p>If the MCO delegates the monthly FTF requirement to a community-based care manager, the documentation must evidence: the care manager has a close collaborative relationship with the WICT Core Team, the member's care plan includes information about the delegation, and case notes demonstrate reciprocal communication between the WICT Core Team and the community-based case manager.</p>	<p>BC+/SSI-DHS 2025 Contract, Article IIIC.2.b.ii</p> <p><i>At a minimum, a team member of the WICT Core Team must meet once a month in-person with the member to discuss the member's care. The in-person meeting with the WICT member may be completed by a community-based case manager if the case manager has a close, collaborative relationship with the WICT Core Team that is demonstrated in the member's care plan and includes reciprocal communication between the WICT Core Team and the community-based case manager.</i></p>

	<ul style="list-style-type: none"> <li>ii. Care plan documentation of the delegation</li> <li>iii. Case note documentation of reciprocal communication between the WICT team and community-based care manager</li> </ul>	<p>Applies only to records that have a WICT assignment and where the member is assigned to WICT for at least one month.</p> <p>CY 26 Changes: Added WICT contact tracking.</p>	
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