

Wisconsin Department of Health Services (DHS)
Division of Medicaid Services
HMO Quality Guide

Measurement Year (MY) 2018

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

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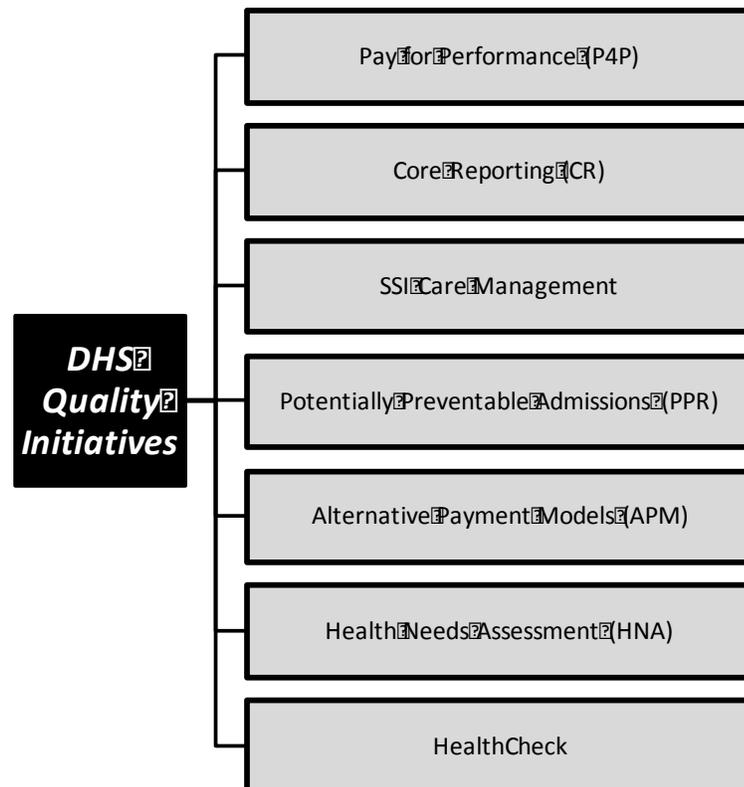
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I. Measurement Year 2018 (MY 2018) Overview

The quality initiatives of the Wisconsin Department of Health Services (DHS) cover a wide range, as shown below:



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

DHS plans to include results for all the above quality measures in its HMO Report Cards. Some measures may be calculated by the DHS' analytics vendor. The HMO Report Card is publicly available on the DHS website (www.forwardhealth.wi.gov).

- 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 an on-going assessment and alignment of the members' needs with their care.
- The **PPR** initiative focuses on reducing preventable hospital readmissions following an initial admission. Excess readmissions compared to state-wide benchmarks suggest an opportunity to improve patient outcomes and to reduce costs through better discharge planning, better coordination of care across sites of service, and/or other improvements in the delivery of care. The Department has allocated up to \$9 million that could be earned by HMOs based on their observed reductions in PPRs.
- The **APM** initiative is aligned with Learning Action Network (LAN)'s goals to move "payments away from Fee-for-Service (FFS) and into APMs that reduce the total cost of care (TCOC) and improve the quality of care."
- The Department's **Health Needs Assessment (HNA)** initiative focuses on newly enrolled childless adult members, and has been a requirement since the 2014-2015 BadgerCare Plus HMO Contract.
- **HealthCheck** (Wisconsin's EPSDT Program) is a preventive health check-up program for anyone under the age of 21 who is currently eligible for Wisconsin Medicaid or BadgerCare Plus.

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

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

II. Pay-for-Performance (P4P)

A. Scope

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

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

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

B. Measures, Withhold and Targets

1. The DHS extensively uses HEDIS measures for its P4P initiative; please refer to HEDIS¹ Technical Specifications published by NCQA² for details of specific measures. Additional HEDIS-like measures supplement the HEDIS measures, as needed; these additional measures are described in this Guide.
 - **BC+**: Total of 14 measures (10 HEDIS, 4 HEDIS-like). Two of these 14 measures were previously Pay-for-Report (P4R) measures; they will be Pay-for-Performance measures in MY2018.
 - **SSI**: Total of 9 measures (7 HEDIS, 2 HEDIS-like). Two of these 9 measures were previously Pay-for-Report (P4R) measures; they will be Pay-for-Performance measures in MY2018.
2. The 2018 upfront **withhold rate** is 2.5%, and will apply to all capitation for BC+ and SSI, including administrative payments. If the dental measures apply to an HMO, the withhold rate will be 2.5% of the dental capitation payment.

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

¹ Health Effectiveness Data and Information Set

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

All measures listed below are designated as P4P (Pay-for-Performance) for MY2018.

Medical Quality Measures and Withhold – 2.5% of medical capitation

Focus Area	MY2018 Measures	BC+ Withhold	SSI Withhold
Preventive / Screening	Breast Cancer Screen (BCS)	0.25%	0.30%
	Childhood Immunization (CIS) – Combo 3	0.25%	N/A
Chronic Care	Comprehensive Diabetes Care - HbA1c Test	0.25%	0.30%
	HbA1c Control (<8.0%) - NQF # 0575	0.125%	0.15%
	Controlling BP (CBP) - NQF # 0018	0.125%	0.15%
Mental Health & Substance Abuse	Depression Medication (AMM - Continuation)	0.25%	0.30%
	AODA (IET - Engagement)	0.25%	0.30%
	Tobacco (Counseling only) – non-HEDIS	0.25%	0.30%
	Follow-up after inpatient discharge (FUH30)	0.25%	0.30%
Pregnancy / Birth	Prenatal and Post-partum care (PPC) – 2 measures	0.125% + 0.125%	N/A
Emergency	ED Visits (AMB) sans revenue code 0456	0.25%	0.40%
	TOTAL	2.5%	2.5%

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

Focus Area	MY2018 Measures	BC+ Withhold	SSI Withhold
Dental Care	Children (ADV + dental care provided by physicians); non-HEDIS	1.25%	N/A
	Adults (similar to children’s measure except for age range and relevant codes); non-HEDIS	1.25%	N/A

3. The DHS utilizes NCQA’s Quality Compass data for Medicaid and HMO-specific performance data as key inputs for setting two types of P4P targets:
- **Level Targets:** Level targets are based on NCQA’s Quality Compass (national Medicaid) percentiles, or State-wide averages, as applicable. The Level targets aim to reward HMOs that perform at high average levels. All HMOs have the same Level target for a measure.
 - **Reduction in Error (RIE) Targets,** also known as Degree of Improvement: The RIE targets require a baseline, established from past performance data. The RIE targets aim to reward HMOs that make significant improvements over time, even if their Level performance does not meet targets. The RIE methodology recognizes “diminishing returns” as performance improves, i.e., moving 5 percentage points from 65% to 70% is not the same as moving 5% percentage points from 85% to 90%. RIE targets are specific to each HMO for each measure, since they are based on the past performance of each HMO.

MY2018 targets for BC+ and SSI for both, Level and RIE, are presented in the tables below.

- a. Some HMOs that served Medicaid members in 2016 have since withdrawn from serving Medicaid members, or have merged. Therefore, for MY2018, the state averages used to set baselines are calculated using MY2016 data for HMOs serving Medicaid members in 2018, and are, therefore, not identical to the MY2016 P4P results.
- b. MY2018 baselines for measures calculated by DXC use different specifications from those used to calculate MY2016 P4P results. Baselines and results for MY2017 and beyond will exclude members with commercial insurance (per the updated HEDIS specs) and will include the Childless Adult (CLA) population, as applicable.
Wisconsin averages for MY2018 baselines are shown in the 2nd column from left, in the tables below.
- c. Starting with measurement year 2017, DHS will use the latest HEDIS version specified by NCQA (e.g., HEDIS 2018 for MY2017, HEDIS 2019 for MY2018) when calculating results for a measurement year, similar to what HEDIS auditors do. If HEDIS specifications allow any optional exclusion / inclusion, DHS will use the option that minimizes the impact of change in specifications on the results (i.e., the option that stays closest to how the Reduction in Error targets and baselines were calculated).

BC+ MY2018 P4P Targets													
P4P Measure	MY2018 baseline WI Avg	NCQA percentiles (CY2016, aka HEDIS 2017)						Level Target			RIE Target		
		25 th	33 rd	50 th	67 th	75 th	90 th	High	Med	Low	High	Med	Low
AMB - ED Visits ³	59.5 visits	52.3	55.6	62.7	69	72.6	86.4	<=55.6	55.7–62.7	>=62.8	>= 5% of base	2%-4.9%	<=1.9%
AMM (continuation) - Depression Rx	45.9%	32.5	33.9	36.2	39.3	41.1	49.2	>=41.1%	39.3%-41.0%	<=39.2%	>=5%	2%-4.9%	<=1.9%
Breast Cancer Screen (BCS)	67.3%	52.7	54.8	59	63	65.5	70.3	>=65.5%	63%-65.4%	<=62.9%	>=10%	5%-9.9%	<=4.9%
CDC-HbA1c Test (Diabetes)	91.4%	84.3	85.4	87.1	88.9	90.1	92.8	>=90.1%	88.9%-90%	<=88.8%	>=10%	5%-9.9%	<=4.9%
CDC – HbA1c Control < 8	51.5%	41.9	45	48.9	51.8	53.7	59.1	>=53.7%	48.9%-53.6%	<=48.8%	>=10%	5%-9.9%	<=4.9%
Controlling BP (CBP)	58.8%	47.7	51.3	56.9	63.1	64.8	71.7	>=63.1%	56.9%-63%	<=56.8%	>=10%	5%-9.9%	<=4.9%
CIS - Childhood Immunization (Combo 3)	74.4%	65.3	67.8	71.6	74.4	75.9	79.3	>=75.9%	71.6%-75.8%	<=71.5%	>=10%	5%-9.9%	<=4.9%
FUH-30	71.9%	55.9	60.3	65.4	72	74.1	80.1	>=74.1%	65.4%-74%	<=65.3%	>=10%	5%-9.9%	<=4.9%
IET Engagement - AODA	14.4%	7.9	9.6	12.3	14.7	16.1	20.8	>=16.1%	12.3%-16%	<=12.2%	>= 5%	2%-4.9%	<=1.9%
PPC – Prenatal care	83.5%	77.7	79.9	83.6	86.8	88.6	91.7	>=88.6%	79.9%-88.5%	<=79.8%	>=10%	5%-9.9%	<=4.9%
PPC - Post-partum care	66.1%	59.6	61.1	64.4	67.8	69.4	73.7	>=69.4%	64.4%-69.3%	<=64.3%	>=10%	5%-9.9%	<=4.9%
Tobacco (Counseling) ⁴	65.3%	N/A	N/A	N/A	N/A	N/A	N/A	>=68.8%	63.6%-68.7%	<=63.5%	>=10%	5%-9.9%	<=4.9%
Dental – Children	54.9%	46.3	48.9	54.9	60.5	62.5	66.9	>= 54.9%	48.9%-54.8%	<=48.8%	>=7%	4%-6.9%	<=3.9%
Dental - Adults ⁵	34.1%	N/A	N/A	N/A	N/A	N/A	N/A	>=36.7%	31.5%-36.6%	<=31.4%	>=7%	4%-6.9%	<=3.9%

SSI MY2018 P4P Targets													
P4P Measures	MY2018 baseline WI Avg	NCQA percentiles (CY2016, aka HEDIS 2017)						Level Target			RIE Target		
		25 th	33 rd	50 th	67 th	75 th	90 th	High	Med	Low	High	Med	Low
AMB - ED Visits ⁶	114 visits	N/A	N/A	N/A	N/A	N/A	N/A	<=108.3	108.4-119.7	>=119.8	>= 5%	2%-4.9%	<=1.9%

³ AMB (excludes revenue code 0456) is a “reverse” measure – lower numbers are better; MY2016 specs exclude Childless Adults; MY2018 specs include them.

⁴ Tobacco – Level: High = 2018 average baseline + (~10% of RIE); Medium = 2018 average baseline – (~5% of RIE)

⁵ Dental – Adults – Level: High = 2018 average baseline + (~4% of RIE); Medium = 2018 average baseline – (~4% of RIE)

SSI MY2018 P4P Targets													
P4P Measures	MY2018 baseline WI Avg	NCQA percentiles (CY2016, aka HEDIS 2017)						Level Target			RIE Target		
		25 th	33 rd	50 th	67 th	75 th	90 th	High	Med	Low	High	Med	Low
AMM (continuation) - Depression Rx	45.4%	32.5	33.9	36.2	39.3	41.1	49.2	>=41.1%	39.3%-41%	<=39.2%	>=5%	2%-4.9%	<=1.9%
Breast Cancer Screen (BCS)	64.8%	52.7	54.8	59	63	65.5	70.3	>=65.5%	63%-65.4%	<=62.9%	>=10%	5%-9.9%	<=4.9%
CDC-HbA1c Test (Diabetes)	91.2%	84.3	85.4	87.1	88.9	90.1	92.8	>=90.1%	88.9%-90%	<=88.8%	>=10%	5%-9.9%	<=4.9%
CDC – HbA1c Control < 8 (Diabetes)	49%	41.9	45	48.9	51.8	53.7	59.1	>=53.7%	48.9%-53.6%	<=48.8%	>=10%	5%-9.9%	<=4.9%
Controlling BP (CBP)	58.6%	47.7	51.3	56.9	63.1	64.8	71.7	>=63.1%	56.9%-63%	<=56.8%	>=10%	5%-9.9%	<=4.9%
FUH-30 - Follow-up after MH inpatient discharge	69.1%	55.9	60.3	65.4	72	74.1	80.1	>=72%	65.4-71.9%	<=65.3%	>=10%	5%-9.9%	<=4.9%
IET Engagement - AODA	8.3%	7.9	9.6	12.3	14.7	16.1	20.8	>=14.7%	9.6%-14.6%	<=9.5%	>=5%	2%-4.9%	<=1.9%
Tobacco (Counseling) ⁷	67.1%	N/A	N/A	N/A	N/A	N/A	N/A	>= 70.4%	65.5%-70.3%	<=65.4%	>=10%	5%-9.9%	<=4.9%

⁶ AMB (excludes revenue code 0456) is a “reverse” measure – lower numbers are better. Level: High = ~0.95*MY2018 average baseline; Medium = ~1.05*MY2018 average baseline

⁷ Tobacco – Level: High = 2018 average baseline + (~10% of RIE); Medium = 2018 average baseline – (~5% of RIE)

C. Non-HEDIS measure specifications

The following statement pertains to non-HEDIS measures that are calculated by DHS's analytics agent, DXC.

During 2018, HEDIS 2018 specifications will be used to calculate MY2017 results, and HEDIS 2019 specifications will be used to set targets for MY2019. This approach will allow the DHS to use the latest available specs for results and for targets, respectively, and is aligned with how HEDIS auditors use HEDIS specifications.

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

- **Measure description:** The % of members 2-20 years of age who had at least one dental visit during the measurement year.
- **Specifications:** The DHS will use the 2019 HEDIS specifications for calculating the results for Annual Dental Visits (ADV). Dental services can be provided by a dental practitioner or a physician. For this measure, a dental practitioner is defined as follows:
 - Per HEDIS, only services rendered by a practitioner who holds a **Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD)** degree from an accredited school of dentistry and is licensed to practice dentistry by a state board of dental examiners.
 - Per HEDIS, **certified and licensed dental hygienists** are considered dental practitioners.
 - Per DHS definitions, dental services (included in the value set) provided by a **physician** would also count.

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

- **Measure description:** The % of members 21-64 years of age who had at least one dental visit during the measurement year. This is a non-HEDIS measure, developed by DHS.
- **Denominator:**
 - Age: from 21 to 64 years of age.
 - Continuous Enrollment: The member needs to be enrolled in the same HMO continuously for 11 months of the measurement year.
 - Anchor Date: the member needs to be enrolled in the HMO as of Dec. 31 of the measurement year.
- **Numerator:** One or more dental visits with a dental practitioner (see definition above) or a physician during the measurement year. A member had a dental visit if a claim or encounter submitted contains any code listed below:
 - CPT Codes: 70300, 70310, 70320, 70350, 70355, 99188.
 - CDT Codes: D0120-D0999; D1110-D1999; D2140-D2999; D3110-D3999; D4210-D4999; D5110-D5899; D6010-D6199; D6205-D6999; D7111-D7999; D8010-D8999; D9110-D9975, D9999.
 - CDT Codes Excluded: D0145, D0411, D1120, D5900-D5999, D6985, D8030, D8080, D9311, D9985-D9987, D9991- -D9996.

- CDT Codes removed from the 2019 Dental Procedure Code Set will not be included in the numerator.

Emergency Room Utilization

- **Measure description:** Number of Emergency Department visits per 1000 member months; this is a utilization measure.
- **Specifications:** The DHS will use the HEDIS 2019 specifications and value sets for the MY2018 results for Ambulatory Care – ED Visits (AMB), excluding revenue code 0456 (Urgent Care).
- **Denominator:** Number of member months during measurement year.
- **Numerator:** Number of Emergency Department visits during the measurement year that do not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.
 - Codes to identify Emergency Department Visits
 - An ED Visit in the HEDIS ED Value Set **excluding** revenue code 0456.
 - A procedure code in the HEDIS ED Procedure Code Value Set with an ED place of service code in HEDIS ED POS Value Set.
- **Exclusions:**
 - ED Visits that result in Inpatient Stays
 - ED visits that result in an inpatient stay as defined in the HEDIS Inpatient Stay Value Set are excluded.
 - Behavioral Health
 - The measure does not include mental health or chemical dependency services. The exclusions defined in the HEDIS 2019 Volume 2 Value Set Directory will apply, and include the following:
 - Electroconvulsive Therapy Value Set
 - Mental and Behavioral Disorders Value Set
 - Psychiatry Value Set

Tobacco Cessation – Counseling

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

- Event/Diagnosis: Members are part of the eligible population if they are identified as tobacco users by having at least one encounter or claim in the measurement year with the following codes:
 - ICD-10-CM F17200, F17201, F17203, F17208, F17209, F17210, F17211, F17213, F17218, F17219, F17220, F17221, F17223, F17228, F17229, F17290, F17291, F17293, F17298, F17299, Z716, Z720.
 - All CPT codes are included even from professional, inpatient, or outpatient claims.
- **Exclusions:** Members who have a diagnosis of history of tobacco use, pregnancy, or tobacco use disorder complicating pregnancy during the measurement year:
 - History of Tobacco Use: ICD-10-CM code Z87891.
 - **Pregnancy Diagnosis:** ICD-10 CM codes O0000 – O9A53, Z331-Z333, Z3400-Z3493, Z360-Z369, Z3A00-Z3A49, Z370-Z379.
 - Tobacco Use Disorder Complicating Pregnancy and ICD-10-CM codes O99330, O99331, O99332, O99333.
- **Numerator:** The member is numerator compliant if he or she received counseling to quit smoking either face-to-face or by phone as identified by any claim or encounter with at least one of the codes listed in Table TBC-A during the measurement year and with the following codes in the same encounter:
 - ICD-10-CM F17200, F17201, F17203, F17208, F17209, F17210, F17211, F17213, F17218, F17219, F17220, F17221, F17223, F17228, F17229, F17290, F17291, F17293, F17298, F17299, Z716, Z720.

Table TBC-A: Codes to Identify Tobacco Cessation Counseling

CPT	HCPCS	ICD-10-CM
96150-96154, 99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397, 99401 -99404, 99406, 99407, 90832-90834, 90836-90838, 90845, 90847, 90849, 90853, 90875, 90876, 90880, 90899, 98967-98968, 99442-99443.	G9016 S9453	F17200, F17201, F17203, F17208, F17209, F17210, F17211, F17213, F17218, F17219, F17220, F17221, F17223, F17228, F17229, F17290, F17291, F17293, F17298, F17299, Z716, Z720.

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

D. Performance Measurement and Earn-back Methodology

Performance for **Level** targets will be measured by comparing MY2018 results of an HMO with MY2016 national Medicaid HEDIS percentiles for HMOs as reported in NCQA’s Quality Compass; these targets are set in advance and included in this Guide. When Medicaid HEDIS results are not available, the appropriate State-wide or Region-wide averages will be used. BC+ and SSI could have different level targets for the same measures due to the differences in the two populations.

Performance for **RIE** targets will be measured by comparing MY2018 results with baseline MY2016 results of an HMO using the percentage “reduction in error” approach.

- When previous years’ data are not available to calculate the “improvement” baseline for an HMO, state-wide averages will be used as that HMO’s baseline.
- DHS will specify and/or provide baseline data to HMOs for MY2018, as appropriate.
- HMOs that are new to Medicaid will not have their withhold at risk in their first full or partial year of P4P participation. Their withhold will be returned at the time other P4P payments are made for a particular measurement year. Such HMOs will be subject to full P4P requirements in their second year of participation.

No ICD-10 modifications are required for MY2018, since the baselines (using MY2016) and the MY2018 results will be based on ICD-10.

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

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

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

* **1% Adjustment to “No Earn Back”**: For MY2018 and beyond, if an HMO receives a **LOW** rating for a measure for both, Level and RIE, AND it misses its Medium target for Level by less than 1% point, the HMO will be eligible to earn back 50% of its withhold for that measure. For the **ED Utilization measure** (AMB, which is not a rate but the # of ED visits per 1000 member months), the adjustment will be 0.5 ED visit per 1,000 member months for BC+, and 1 ED visit per 1,000 member months for SSI. These adjustments are close to 1% of the state average for each population. The 1% adjustment does not apply to RIE targets. The adjustment will not be available to an HMO if its performance for that measure declines from the previous year.

Reduction in Error (RIE) Example:

The degree of improvement achieved by an HMO is defined as the percentage “Reduction In Error” (RIE) for a given measure in MY2018, compared to its baselines for that HMO.

Consider the following **example**:

1. Assume an HMO’s score for a measure for MY2016 was 80%. This forms the RIE baseline, and its MY2016 “error” = 100% - 80% = 20 percentage points.
2. If an HMO attains a score of 82% in MY2018, then it would have achieved a 10% RIE, calculated as:
 - Percentage point increase from last year = 82% - 80% = 2 percentage points
 - This 2% represents one-tenth (or 10%) of the error in MY2016, which was calculated to be 20 percentage points, above.
3. Looking at it from a different point, if an HMO attained a score of 80% in MY2016, it can demonstrate a 10% RIE in MY2018 by attaining a score of 82% in MY2018, because:
 - MY2018 “error” = 100% - 80% = 20 percentage points.
 - 10% reduction in this error = (10% * 20%) = 2 percentage points.
 - 80% + 2% = 82%.
4. If the MY2018 score = 81%, then that HMO will have improved its score by 1 percentage point, which is equal to a 5% reduction in error.

Mathematically, the % RIE for MY2018 = $\{(MY2018 - MY2016) / \text{Error}\} * 100$, where Error = (100 - MY2016).

Current Methodology Example – Level and RIE:

The steps in the example (using hypothetical numbers) below demonstrate how Level and RIE ratings would be calculated under the current methodology.

(a) Set the **MY2018 performance targets** for Level and RIE. Assume MY2016 National Medicaid Quality Compass⁸ data for a given measure are:

⁸ Quality Compass data for MY2016 refers to data reported by NCQA for Calendar Year 2016. NCQA released this data in 2017, and labeled it HEDIS 2017.

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

Then, the MY2018 Level targets are:

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

Also assume that the MY2018 RIE targets are:

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

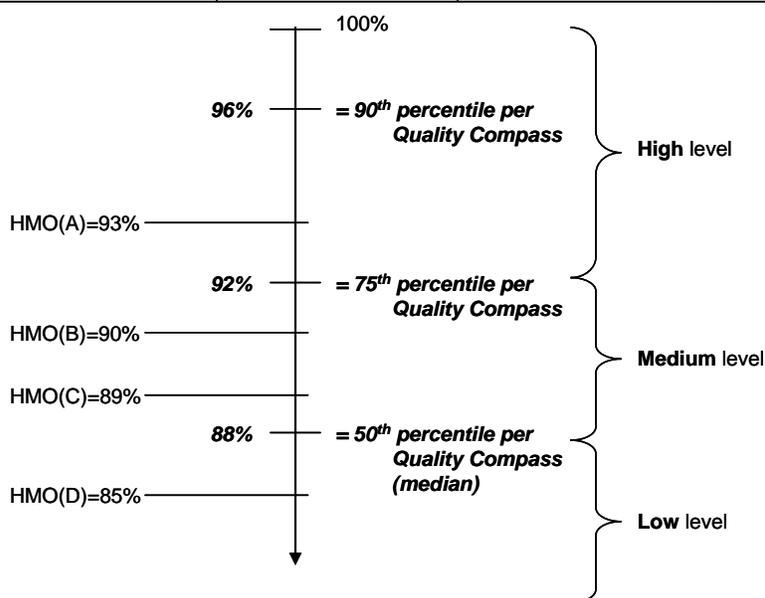
(b) When MY2018 performance data are available, first determine the **Level ratings** for each HMO for each measure, as shown in the following example.

Assume that scores of four HMOs are:

HMO	MY2018 Score
A	93%
B	90%
C	89%
D	85%

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

HMO	MY2018 Score	Level rating	Rationale
A	93%	High	Higher than 75 th percentile score
B	90%	Medium	Between 50 th and 75 th percentile
C	89%	Medium	Between 50 th and 75 th percentile
D	85%	Low	Below 50 th percentile



(c) Calculate the **% RIE** for each HMO for that measure (based on MY2016 scores).

HMO	MY2018 Score	MY2016 Score	MY2018 – MY2016	MY2016 Error	RIE rating	
A	93%	93%	0% points	7% points	= (0/7)*100 = 0%	Low
B	90%	89%	1% points	11% points	= (1/11)*100 = 9.1%	Medium
C	89%	89%	0% points	11% points	= (0/11)*100 = 0%	Low
D	85%	83%	2% points	17% points	= (2/17)*100 = 11.8%	High

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

HMO	MY2018 Level rating	MY2018 RIE rating	Withhold earned back
A	High	Low	100%
B	Medium	Medium	75%
C	Medium	Low	50%
D	Low	High	100%

Examples for AMB (ED visits) Measure:

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

- MY2016 BC+ State average score (base) = 49.3 ED visits/1000 member months.
 - MY2018 BC+ **Level** targets are: High: HMO score <= 50.5 ED visits / 1000 member months; Medium: HMO score between 50.6 and 55; Low: HMO score >= 55.1 visits.
 - MY2016 BC+ **RIE** targets: High: HMO achieves a 5% or higher reduction of its **base**; Medium: HMO achieves 3% to 4.9% reduction; Low: HMO achieves 2.9% or lesser reduction.
1. Assume an HMO's MY2016 score for AMB is 55 (= base), and the MY2018 score is 50 visits.

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

2. Assume an HMO's MY2016 score is 56 (= base), and the MY2018 score is 53.

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

3. Assume an HMO's MY2016 score is 53 (= base), and the MY2018 score is 51.

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

4. Assume an HMO's MY2016 score is 54 (= base), and the MY2018 score is 53.

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

5. Assume an HMO's MY2016 score for AMB is 58 (= base), and the MY2018 score is 57.

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

* Unless the "1% adjustment" applies.

E. Bonus

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

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

MY2018: Minimum # of applicable P4P measures for bonus eligibility	
BC+ (non-dental)	6 out of 10 P4P measures
BC+ (dental only)	2 out of 2 P4P measures
SSI	4 out of 7 P4P measures

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

Separate bonus pools for BC+ dental and non-dental measures, 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 measure, subject to the bonus limits. Rationale:

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

Example of bonus calculations

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

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

F. Data Submission and Reporting for BC+ and SSI

1. Submitting / calculating results

The following table shows who will calculate / submit results for each measure for MY2018:

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

2. Member Level Detail files not required

In previous years, HMOs were asked to be ready to submit member-level data for HEDIS measures that were calculated and submitted by HMOs. NCQA recently announced that only Medicare HMOs are subject to that requirement. Therefore, for MY2017 (aka HEDIS 2018) and beyond, HMOs do **NOT** need to prepare the member-level data for the Department.

3. Supplemental data

HMOs may submit **additional / supplemental data (member level detail is required)** to augment results for measures calculated by DXC. Supplemental data are in addition to and different from the administrative data and the Medical Record Encounter (explained below). Such data should be submitted via SFTP, and may pertain only to data collected through chart review or other means.

If an HMO desires to submit supplemental data for up to **less than 25 members** across **all** measures for the MY, it may submit data directly to the DHS staff using SFTP. HMOs are asked to inform the DHS staff separately if they submit **any** data through SFTP.

If an HMO desires to submit quality data for 25 or more members across all measures for the MY, it should follow the Medical Record Encounter Guidance, discussed later in this section.

Intent to submit

HMOs intending to submit supplemental member-level data should notify DHS via email (to Jose.Bocanegra@dhs.wisconsin.gov) **within 1 week of receiving the preliminary results calculated by DXC**. The email should include:

- A list of the measures for which the HMO intends to submit supplemental data
- Target populations (BC+ and/or SSI)
- Estimated # of records the HMO plans to submit for each measure.

Specific submission requirements

HMOs submitting member-level data to supplement their P4P results **must** comply with all of the following requirements:

1. Submit member-level data saved as separate Excel worksheets for BC+ and SSI populations. An HMO submitting data for multiple measures for both populations must submit one excel file with different worksheets clearly labeling the measure and the population, e.g., AMB for BC+, AMB for SSI, Tobacco for SSI, Dental-Children, Dental-Adult, etc.
2. Place all member-level excel files in each HMO's SFTP folder and send an email to VEDSHMOSupport@wi.gov and Jose.Bocanegra@dhs.wisconsin.gov to notify DHS that the files have been uploaded with the name(s) of the files.
3. Send all member-level files to DHS **by the date specified in Section I, "Timeline for 2018"**. DHS will not be able to review files submitted after the due date.
4. Provide electronic copies of the chart data included in the supplemental member-level files made available to DHS.
 - Chart data must be embedded as a PDF or word document within the appropriate member row in each measure worksheet.

The **required data elements** for each measure for which supplemental data can be submitted are listed below:

AMB – Emergency Department Utilization

1. Member's Medicaid ID
2. Member's Date of Birth - MM/DD/YYYY
3. Whether the member is already included in HP's denominator? – Yes or No
4. Should member be removed from the denominator? – Yes or No
5. Does the HMO have different member months for this member than HP? – Yes or No
6. Number of months the member was enrolled in the HMO during the measurement year - MM (member months)
 - Example: If a member was enrolled for four months as a BadgerCare Managed Care member and eight months as a SSI Managed Care member, please include "04" in the BadgerCare Plus AMB spreadsheet and "08" in the SSI AMB spreadsheet for your HMO.

7. Procedure code for the Emergency Department (ED) visit (if applicable) – In the HEDIS AMB ED value set or in the ED procedure code value set
8. Place of service for the ED visit (if applicable) – In the HEDIS AMB ED place of service value set
9. Revenue code for the ED visit (if applicable) – In the HEDIS AMB ED value set
10. Date of ED visit – MM/DD/YYYY
11. Is the ED visit In HP's numerator? – Yes or No
12. Should ED visit be removed from the numerator? – Yes or No
13. Principal diagnosis code for mental health of chemical dependency during ED visit - In the HEDIS mental and behavioral disorders value set; if not applicable, write "NA".
14. Procedure code of psychiatry during ED visit - In the HEDIS psychiatry value set; if not applicable, write "NA".
15. Procedure code of electroconvulsive therapy during ED visit - In the HEDIS electroconvulsive therapy value set; if not applicable, write "NA".
16. Procedure code of alcohol or drug rehabilitation or detoxification during ED Visit – In the HEDIS AOD rehab and detox value set; if not applicable, write "NA".
17. ICN# for ED visit - If this information comes from chart data, please write "Chart" and send electronic copies of the chart data in a separate file.
 - Note: ICN numbers are provided by DHS to HMOs in the weekly encounter response file for every encounter that was processed by HP. Please do not submit your own internal claim number.
18. Chart Data

Tobacco Cessation Counseling

1. Member's Medicaid ID
2. Member's date of birth - MM/DD/YYYY
3. Member's age in Measurement Year – YY
 - Note: For example, if a member turned 50 in the measurement year, please send 50.
4. Is the Member in HP's denominator? – Yes or No
5. Date the Member enrolled in the HMO - MM/DD/YYYY
6. If Member disenrolled from HMO during the Measurement Year (MY), submit the HMO disenrollment date – MM/DD/YYYY; if not applicable, write "NA".
7. Months of continuous BadgerCare Plus or SSI eligibility in MY - MM
8. Was the Member enrolled in the HMO on Dec. 31, 2014? - Yes or No
9. Diagnosis code that identifies Member as tobacco user – ICD-9 CM or ICD-10 tobacco addiction diagnosis code
 - Note: See tobacco cessation specifications for a list of qualifying diagnosis codes.
10. Date of tobacco diagnosis - MM/DD/YYYY
11. ICN # for encounter with tobacco cessation diagnosis – If this information comes from chart data, please write "Chart" and send electronic copies of the chart data in a separate file.
 - Note: ICN numbers are provided by DHS to HMOs in the weekly encounter response file for every encounter that was processed by HP. Please do not submit your own internal claim number.

12. Should the member be removed from the denominator? – Yes or No.
13. Diagnosis of history of tobacco use – ICD-9-CM or ICD-10-CM codes. If not applicable, write “NA”.
 - Note: See tobacco cessation specifications for a list of qualifying diagnosis codes.
14. Pregnancy diagnosis – ICD-9-CM or ICD-10-CM codes. If not applicable, write “NA”.
 - Note: See tobacco cessation specifications for a list of qualifying diagnosis codes.
15. ICN # for tobacco exclusion diagnosis – If this information comes from chart data, please write “Chart” and send electronic copies of the chart data in a separate file.
 - Note: ICN numbers are provided by DHS to HMOs in the weekly encounter response file for every encounter that was processed by HP. Please do not submit your own internal claim number.
16. Procedure code for the encounter in which tobacco cessation counseling was provided – If not applicable, write “NA”.
 - Note: See tobacco cessation specifications for a list of qualifying procedure codes.
17. Diagnosis code to identify that tobacco cessation counseling was addressed by provider during the encounter referenced in #15 – ICD-9 CM or ICD-10 tobacco addiction diagnosis code.
 - Note: See tobacco cessation specifications for a list of qualifying diagnosis codes.
18. HCPCS code for the encounter in which tobacco cessation counseling was provided – If not applicable, write “NA”.
 - Note: See tobacco cessation specifications for a list of qualifying HCPCS codes.
19. Date of service when tobacco cessation counseling was provided - MM/DD/YYYY
20. ICN # for tobacco cessation counseling encounter – If this information comes from chart data, please write “Chart” and send electronic copies of the chart data in a separate file.
 - Note: ICN numbers are provided by DHS to HMOs in the weekly encounter response file for every encounter that was processed by HP. Please do not submit your own internal claim number.
21. Chart Data

Annual Dental Visit for Children

1. Member’s Medicaid id
2. Member’s date of birth - MM/DD/YYYY
3. Member’s age in Measurement Year – YY
 - Note: For example, if a member turned 5 in the measurement year, please send 5.
4. Is the Member in HP’s denominator? – Yes or No
5. Date the Member enrolled in the HMO - MM/DD/YYYY
6. If Member dis-enrolled from HMO in MY, submit the HMO disenrollment date – MM/DD/YYYY; if not applicable, write “NA”.
7. Months of continuous BadgerCare Plus eligibility in MY - MM
8. Was the Member enrolled in the HMO on Dec. 31, 2014? - Yes or No
9. Procedure code to identify qualifying dental encounter in MY– From HEDIS dental visits value set; if not applicable, write “NA”.

10. Dental code to identify qualifying dental encounter in MY– From HEDIS dental visits value set; if not applicable, write “NA”.
11. Date of service for qualifying dental encounter in MY - MM/DD/YYYY
12. ICN # for qualifying dental encounter – If this information comes from chart data, please write “Chart” and send electronic copies of the chart data in a separate file.
13. Note: ICN numbers are provided by DHS to HMOs in the weekly encounter response file for every encounter that was processed by HP. Please do not submit your own internal claim number.
14. Chart Data

Annual Dental Visit for Adults

1. Member’s Medicaid ID
2. Member’s date of birth - MM/DD/YYYY
3. Member’s age in Measurement Year – YY
 - Note: For example, if a member turned 50 in the measurement year, please send 50.
4. Is the Member in HP’s denominator? – Yes or No
5. Date the Member enrolled in the HMO - MM/DD/YYYY
6. If Member disenrolled from HMO in MY, submit the HMO disenrollment date – MM/DD/YYYY; if not applicable, write “NA”.
7. Months of continuous BadgerCare Plus eligibility in MY - MM
8. Was the Member enrolled in the HMO on Dec. 31, 2014? - Yes or No
9. Procedure code to identify qualifying dental encounter in MY– If not applicable, write “NA”.
 - Note: See Annual Dental Visit for Adults specifications for a list of qualifying procedure codes.
10. Dental code to identify qualifying dental encounter in MY– If not applicable, write “NA”.
11. Note: See Annual Dental Visit for Adults specifications for a list of qualifying dental codes.
12. Date of service for qualifying dental encounter in MY - MM/DD/YYYY
13. ICN # for qualifying dental encounter – If this information comes from chart data, please write “Chart” and send electronic copies of the chart data in a separate file.
 - Note: ICN numbers are provided by DHS to HMOs in the weekly encounter response file for every encounter that was processed by HP. Please do not submit your own internal claim number.
14. Chart Data

4. Medical Record Encounter Guidance (X12 837)

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

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

Background

- a. An encounter record may be created from data acquired through medical record or chart review, or other non-claim sources.
- b. This is done when the HMO wishes to supplement its encounter data set, **but no claim was received for the service provided. Examples include: HealthCheck services, medical records transferred from another state.**
- c. The only medical record/chart reviewed data that may be submitted is information obtained from a provider or clinician, **and must meet the following criteria:**
 - i. The date of service should be within the specifications of the measures for the MY.
 - ii. When a test result is needed, the medical record includes a note indicating the date of service and the result.
 - iii. Electronic supplemental data may be used if the information is related to the disease being managed, the reported value was measured by a health care provider, and the information is either in the member's medical record or the HMO has the ability to access the information (example: WIR).
- d. Member reported biometric values from self-administered tests are not acceptable.
- e. Member survey information may not be used.
- f. If the review supplements an existing encounter record, do not submit the additional data as a medical record reviewed encounter. Adjust or void and resubmit the original encounter.
- g. DMS Required Fields for Medical Record/Chart Review Data (Please work with your technical staff to get the appropriate information from the companion guide).

Required 837 Detail Fields for Medical Record/Chart Review

- a. All HMOs are expected to follow the X12 837 standards when submitting encounter data, even when it comes in by chart review. Included in the 837 standards are instructions for identifying the encounter as a chart review. The list below identifies the fields that are specific to chart reviewed data. Keep in mind that your data submissions should begin with the 837 standards. Please work with your technical staff to utilize the appropriate information from the companion guide.
- b. Loop 2330 NM 109 – Other Payer Primary Identifier (This is the HMO ForwardHealth ID)

- c. Inner Envelope BHT06 – Encounter ID. Use Loop 2300 with PWK01 = 09. Any encounter submitted with 09 in the PWK01 segment will be labeled as a chart review. (Data source 1, 2, 3 is no longer used). These services will not be used for encounter rate setting.
- d. Loop 2300 with PWK – Use this segment when it is necessary to indicate an encounter chart review.
- e. Loop 2300 PWK 01 – Report Type Code = 09 (Encounter). Added element. Element will designate a chart review encounter.
- f. Loop 2300 PWK02 – Attachment Transmission Code AA. This means that the attachment is available by request at provider site.

Chart Review FAQ's

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

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

By December 2018, the DHS plans to provide data to HMOs for members who received care under FFS during the MY, when they were not enrolled in an HMO, so that HMOs can get the credit for care provided while the members were enrolled in FFS. In prior years, HMOs have preferred to receive this data by December, so these FFS files will not reflect the full Measurement Year data due to the associated time lags.

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

HMOs are required to submit the following for MY2018:

- a. Data from the NCQA Interactive Data Submission System (IDSS) site containing the required data elements and the denominator and numerators for each measure in the Data-filled Workbook (export), filled copy of this workbook in Excel format for local copy and for printing. HMOs must provide to the DHS the **denominators and numerators for each measure**.

- b. **Data Filled Workbook, including Audit Review Table (ART) format** downloaded from the NCQA IDSS site (with evidence that the auditor lock has been applied).
- c. The Audit Report produced by a NCQA Licensed HEDIS Auditor.
- d. For measures with age stratification, HMOs are asked to report results in the IDSS and ART tables by age strata as well as for the overall population.

7. Electronic submission requirements:

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

8. Public Reporting

For MY2018, all health plans are asked to report each of their HEDIS scores verified by their HEDIS auditor for all regions, and to make their results available for public reporting within the Quality Compass. As in the past, the DHS (DXC) will calculate the applicable HEDIS-like or non-HEDIS scores (e.g., for tobacco cessation, AMB-ED Visits, Dental measures for children and adults).

9. Other P4P requirements:

- a. Rotation of measures is not allowed. Each measure is to be calculated each year.
- b. Health plans may apply the optional exclusions per HEDIS specifications for appropriate measures while submitting audited Medicaid HEDIS results to NCQA.
- c. In determining continuous enrollment for specific measures, HEDIS allows a gap of 45 days for commercial plans, but only a one-month gap for Medicaid plans that enroll on a monthly basis. Wisconsin Medicaid enrolls members on a monthly basis. The only time a member is not enrolled for the entire month is the month in which a child was born. Refer to the General Guidelines in the HEDIS Technical Specifications.
- d. For HEDIS measures that can be collected using the hybrid method, inclusion of chart review data is optional.
- e. HMOs may use the sample approach to calculate their results when permitted by HEDIS.
- f. HMOs are asked to submit their final version of the encounter data and Medical Encounter Record data for the Measurement Year by the date specified in the Timeline section of this document. These data will be used by the DHS and DXC, its analytics vendor to calculate the results for HEDIS-like measures. Once the encounter data have been extracted by DXC for P4P results, further changes to that data will not be feasible.

G. Participating HMOs

The table below lists the 15 BC+ HMOs and 8 SSI HMOs participating in the P4P and Core Reporting initiatives for MY2018. This list is updated annually.

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

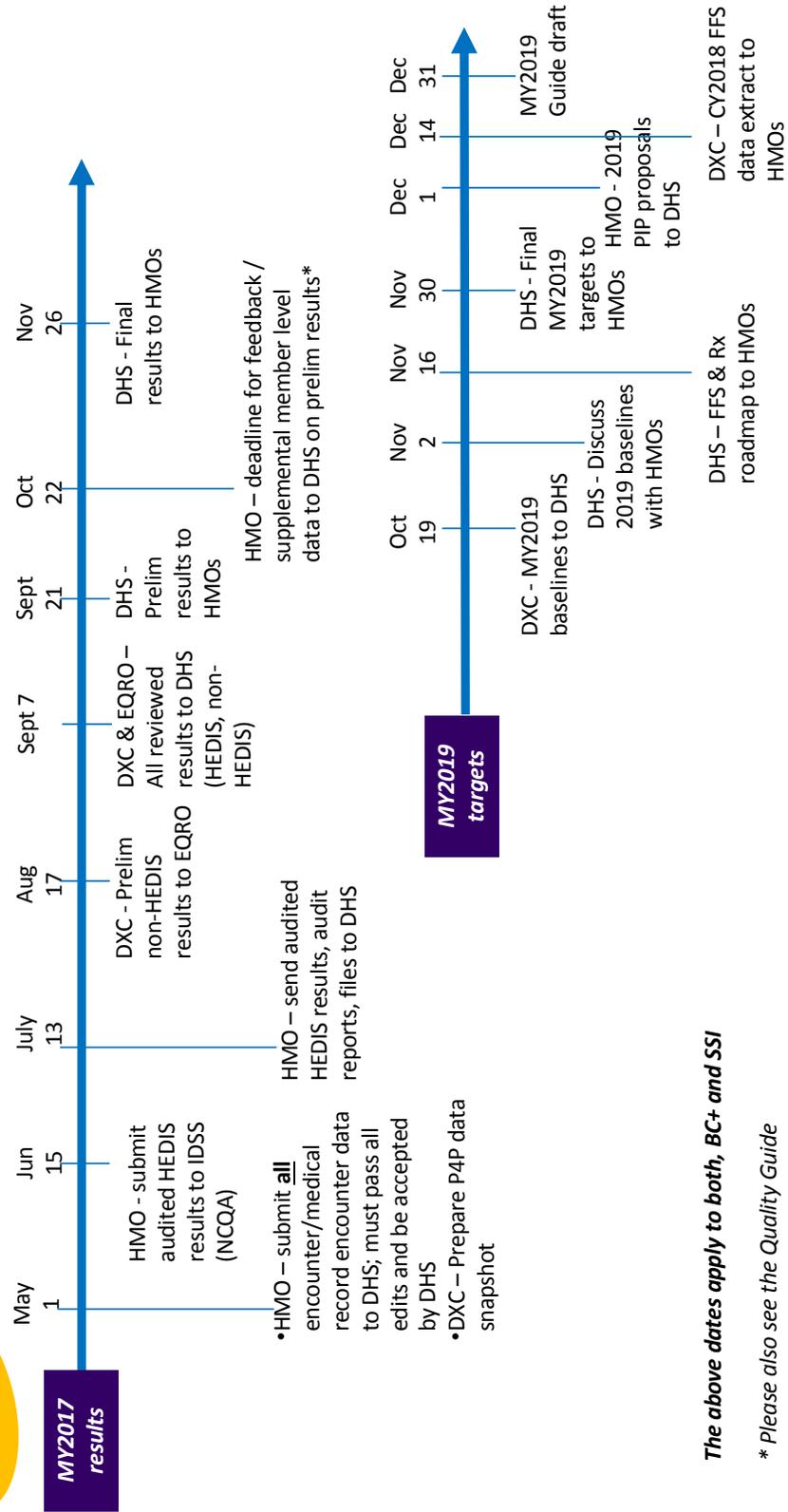
H. HMO P4P Timeline for MY2018

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



HMO P4P Timeline during CY2018 for MY2017 results and MY2019 targets

Updated
2-13-2018



The above dates apply to both, BC+ and SSI

* Please also see the Quality Guide

III. Core Reporting (CR)

As part of its initiatives to improve alignment with current and future CMS requirements (e.g., CHIPRA, Managed Care Rules) and as input to a broader picture of Quality of Care, the DHS requires all plans to report audited HEDIS data for the measures for MY2018 shown in the table below. The Core Reporting measures are not part of P4P withhold or bonus.

HMOs will be subject to a \$10,000 penalty per measure for not reporting HEDIS data for the measures listed below.

Core Reporting Measures		
	BC+	SSI
Preventive / screening	Adult BMI (ABA) Adult access to preventive care (AAP) Adolescent immunization (IMA) Children/adolescent access to preventive care (CAP) Well-child visits in first 15 months (W15) Well-child visits in the Third, Fourth, Fifth and Sixth years (W34) Adolescent well care visits (AWC)	Adult BMI (ABA) Adult access to preventive care (AAP)
Mental health / substance abuse	Mental health utilization (MPT)	Mental health utilization (MPT)
Blood lead testing (LSC)	Target = 75th percentile for MY2016 NCQA Quality Compass (not P4P for MY2018)	N/A

Blood Lead Testing (HEDIS LSC): The MY2018 target for LSC is set at the MY2016 national 75th percentile, at **80.9%**. A flat penalty of \$10,000 (not part of P4P) will be applied to HMOs not meeting the MY2018 target.

HEDIS Depression Measures using ECDS:

Based on the current status of NCQA's two HEDIS Depression measures using Electronic Clinical Data System, namely, Monitor depression symptoms using PHQ-9 (DMS), and Depression remission using PHQ-9 (DRR), the Department has decided to postpone the submission of those two measures for MY2018. **HMOs are not required to collect or submit data for the above two depression measures, or to submit an action plan for submitting data for these measures, for MY2018.**

The Department will review the status of these measures in late MY2018 as part of its planning for MY2019.

IV. SSI Care Management

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

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

Each of the above are described in further detail, below.

G Codes & Modifiers

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

The Department will not require HMOs to self-report operational quality data in MY2018. The Department will calculate the following data points and measures using G Codes and appropriate Modifiers (TG, TF and none):

1. Care Planning (CP1) = % of new members had a care plan within 90 days of enrollment
2. Needs Stratification (NS1) = % of members enrolled each month assigned to WICT
3. Needs Stratification (NS2) = % of members enrolled over the year assigned to WICT
4. Needs Stratification (NS3) = average # of months a member assigned to WICT
5. Needs Stratification (NS4) = % of members enrolled each month assigned to Medium stratum
6. Needs Stratification (NS5) = % of members enrolled over the year assigned to Medium stratum
7. Needs Stratification (NS6) = % of members enrolled each month assigned to Low stratum (=combining all strata below Medium)
8. Needs Stratification (NS7) = % of members enrolled over the year assigned to Low stratum (=combining all strata below Medium)
9. Transition Care (TC1) = % of discharges who received transition care follow-up
10. Transition Care (TC2) = % of discharges who received transition care follow-up within 5 days

Step	Data Reporting Description
Care Planning	<p><u>New members</u> <i>(enrolled after 1/1/2018; not enrolled in the same HMO for the past 6 months or longer):</i></p> <p>(CP1): % of new members with care plans within 90 days of enrollment = # of new members with care plans within 90 days of enrollment / # of new members with 90+ days of continuous enrollment Calculated quarterly by DHS/DXC using code G9001</p> <p><u>Annual Target = 75% of new members should have care plan within 90 days</u></p> <p>Also track timeliness of care planning, from date of enrollment; Calculated quarterly by DHS/DXC using code G9001; Histograms for 90 days, 120 days, 150 days and beyond.</p>
Needs Stratification	<p>Use Care Management (G) codes 9002, 9006, 9007 or 9012; Calculated monthly by DHS/DXC after data submission deadline:</p> <p><u>WICT (up to 5% of SSI membership)</u> <i>Data point 1: # of unique members each month with any <u>G code + TG modifier</u> (= WICT stratum)</i></p> <p>(NS1): % enrollment in WICT for each month = Data point 1 / total # of members enrolled for that month (Assumption: each member in WICT receives at least one WICT related service each month)</p> <p>(NS2): Average % enrollment in WICT over last 12 months = Sum of Data point 1 over last 12 months / # of total member months over last 12 months</p> <p>(NS3): Average # of months in WICT over last 12 months = Sum of # of months each unique member had a WICT code over 12 months / # of unique members with WICT services at any time over last 12 months <i>Create a histogram for NS4 (# of months and corresponding # of members)</i></p> <p><u>Medium stratum (next highest after WICT)</u> <i>Data point 2: # of unique members each month with any <u>G code + TF modifier</u> (= Medium stratum). There is no payment difference between TF modifier and no modifier.</i></p> <p>(NS4): % enrollment in Medium stratum for each month = Data point 2 / total # of members enrolled for that month</p> <p>(NS5): Average % enrollment in Medium stratum over last 12 months = Sum of Data point 2 over last 12 months / total # of member months over last 12 months</p> <p><u>Lower stratum (all combined after Medium)</u> <i>Data point 3: # of unique members each month with any <u>G code + no modifier</u> (= all combined Lower stratum). There is no payment difference between TF modifier and no modifier.</i></p>

Step	Data Reporting Description
	<p>(NS6): % enrollment in Lower stratum for each month = Data point 3 / total # of members enrolled for that month</p> <p>(NS7): Average % enrollment in Medium stratum over last 12 months = Sum of Data point 3 over last 12 months / total # of member months over last 12 months</p>
Transition Care	<p>Calculation frequency TBD; by DHS / DXC</p> <p><i>Data point 4: Total # of discharges from inpatient stay during the reporting period (from DXC)</i> <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> <i>Create a frequency distribution / histogram for data point 5 (# of days for follow-up)</i></p> <p>(TC1): % of all discharges from inpatient stay with a follow-up Transition Care service = Sum of Data point 5 / Data point 4</p> <p>(TC2): Timeliness of Transition Care (within 5 days of discharge) = % of all discharges from inpatient stay with a follow-up Transition Care service within 5 days of discharge = Data point 5 within 5 days / Data point 4</p>

SSI Care Management PIPs focused on Needs Stratification

The Department shared the following guidelines with SSI HMOs in early November 2017 to assist them in preparing their formal 2018 PIP proposals. The guidelines were prepared by the Department’s EQRO, MetaStar.

**Performance Improvement Project
Annual Report Format Guideline**

Reference: EQR Protocol 3, Version 2.0
Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for
External Quality Reviewers (EQR)

Organization:			Report Prepared by:		
Project Title:					
Date Project Initiated:		Date of DHS Approval:		Date Report Submitted:	
Project Team:	Name			Title/Department	

Considerations for Supplemental Security Income (SSI) Needs Stratification PIP are noted in each section below in red.

Study Topic

Describe the process used to prioritize and select this topic from among others as an area identified for improvement. The diagram below represents the SSI Care Management process steps relevant for this PIP proposal. The process starts with Needs Stratification, which includes use of social determinants as one of the inputs. The next step is the creation of an individualized Care Plan, which is updated based on events or time-based protocols related to the Needs Stratum to which an individual member is assigned. The Care Plan is used to manage the delivery of care for the member, including care management related to transitions between places of services, as appropriate. For example, discharge from inpatient care could trigger a review of the Needs Stratum to which the member is assigned, and lead to assignment to a different Stratum and associated care protocols. Such reviews also become part of the Plan-Do-Study-Act (PDSA) cycles that an HMO would use to continuously improve its Needs Stratification methodology.



Include information about:

- The relevance of this topic to the organization’s membership;
 - Identify how it relates to the health and/or functional status of members, and why it is important to members.
 - Describe each of the following:
 1. Definition of the organization’s risk stratification process and level designations;
 2. How the HMO will ensure that it implements a robust stratification methodology, as evidenced by:
 - Clearly defined case management tiers that are evidence-based, and clearly defined cut-off points for each tier. The top-most tier must align with WICT;
 - Demonstrated use of clinical logic, algorithm/software to assign members to tiers; and
 - Demonstrated incorporation of social determinants in assigning members to tiers.
 3. Define PPR and ABR, and the relationship between the organization’s risk stratification process and the Potentially Preventable Readmission (PPR) Actual-to-Benchmark Ratio (ABR). Also provide details of your Logic Model for this PIP including:
 - How your effective needs stratification will lead to individualized and improved care plans; and
 - How your improved care plans, combined with evidence-based care protocols and transitional care, will lead to improved quality of care, and to a reduction in PPR.
- How the topic was initially identified as an opportunity for improvement;
 - Document the needs assessment that helped identify baseline performance, including any data.
 - The PIP proposal should focus on reducing the total ABR for the HMO, and not on ABR for select All Patient Refined – Diagnosis Related Groups (APR-DRGs) for the HMO.
- Any member input obtained in considering this as an opportunity for improvement; and
- The size of the applicable population when selecting a study topic.

Study Questions/Project Aims

State the study question(s) or aim(s) as clear, simple, answerable question(s), including the numerical goal and target date.

- Identify the rate of desired improvement (from what to what) in the study question.

The study question needs to include the intended reduction in the PPR ABR from baseline to the goal, including the target date for such reduction. The study question should read as follows:

Implementation of the risk stratification processes is expected to result in a ____ % reduction in the baseline PPR ABR of [rate supplied by DHS]____ by [DATE]_____.

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

Study Indicators

List all study measures/indicators.

- Define measurable indicators and ensure they adequately answer the study questions, and include the intended impact of the organization's needs stratification process;
- Clearly define all numerators and denominators (PPR and ABR - same as the definition in "Study Topic" section);
- If Healthcare Effectiveness Data and Information Set (HEDIS[®])⁹ measures are used, include the relevant specifications.

Study Population

Describe the relevant population (all members to whom the study question and indicators apply). Make sure to clearly define the population used for the study or project, including any inclusion or exclusion criteria and any enrollment/eligibility criteria (e.g., requirements for how long members had to be enrolled).

- If data for the entire population was studied, describe how the data collection approach captured all members to whom the study question applied.
- All SSI members are included in the study population.

Sampling

If sampling was utilized (data for a sample of the population was studied and findings were generalized to the entire population), explain the sampling methods used in detail (e.g., number included in the sample, sampling technique used, confidence intervals, acceptable margin of error).

- Sampling methods would not be needed as the Needs Stratification PIP should include all SSI members.

⁹ "HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA)."

Data Collection

Study results are dependent on accurate and valid data that are collected appropriately. Clearly describe the data that was collected for all project indicators. Include information about:

- Data sources (e.g., claims/administrative data, member files);
- How data was collected and by whom;
- Any training or educational qualifications required of data collection staff;
- How data was stored and aggregated (e.g., registry, database); and
- How data was analyzed and by whom.

DHS will provide the PPR and G-codes utilization data on a quarterly basis. HMOs must describe how they will analyze that data provided by DHS for the HMO's PDSA (Plan-Do-Study-Act) cycles.

HMOs should not rely only on the data from DHS. HMOs must also utilize internal data sources to obtain real-time results. Clearly define what internal and other data sources will be mined (e.g. risk stratification levels, care plan review dates, transitional care data, WISHIN, electronic medical record review, etc.), frequency of data collection and analysis, and how the data will be used in relation to any PDSA cycles of improvement.

Describe the planned and actual frequency of data collection and analysis. **Include samples of any data collection tools or instruments as an attachment to this report.**

Improvement Strategies

Describe the interventions initiated and/or completed.

- Explain how interventions were selected based on available data, root cause, or barrier analysis;
- **Ensure interventions relate to the reduction in overall / total PPRs, and focus on active care management actions, such as the review of the risk stratification levels on a periodic basis;**
- Indicate the timeframes for intervention implementation;
- For continuing projects, provide documentation that focuses on interventions implemented during the current project period.

Include documentation of continuous cycles of improvement (PDSAs), showing measurement and analysis of the effectiveness of the interventions.

Describe any consideration given to ensuring that interventions were culturally and linguistically appropriate. **Include any materials that were developed and/or used for interventions, such as member educational materials, practice guidelines, etc., as attachments to this report.**

The following information will be reported at the conclusion of the PIP project and does not need to be included in the PIP proposal.

Data Analysis and Interpretation of Study Results

Include relevant data in the report, **including numerators and denominators.**

Include baseline and final data, **as well as periodic data reviewed according to the prospective data analysis plan.**

Provide a discussion of initial, repeat, and final measurement results and how these were interpreted. **Include tables, charts or graphs, when applicable; present numerical results accurately and clearly.**

Analyze and address the impact of identified study limitations or barriers. Include any hypotheses and related analysis when improvement has not been achieved. Document actions taken as a result of analysis.

Report on both internal data (risk level, WISHIN, etc.) and the data provided quarterly by DHS (PPR and G-codes). Describe how these two data sets work together to indicate the study results.

“Real” Improvement

Consider if the repeat measures utilized the same methodology as the baseline and interim measures.

Document any quantitative improvements in processes or outcomes of care associated with the study question.

Determine if any improvement appears to be “real” improvement.

- Identify if improvement is related to the interventions employed or some unrelated occurrence;
- Include information about how the effectiveness of interventions was measured, and how this correlated with the overall project measures and progress (i.e., describe how you determined that the improvement was a result of the intervention employed);
- Note if there is any statistical evidence to suggest that improvement seen is true improvement.

Sustainability

This standard will only be evaluated if improvement has been achieved and measures have been repeated over comparable time periods.

- If improvement has been sustained, describe how sustainability has been achieved.
- If improvement has only recently been achieved, describe the plan to sustain it.

Qualitative EQRO Review of SSI Care Management Process Quality

Overview: For its review, the EQRO will use MMIS data to create samples for each HMO to identify members in WICT, medium, and low strata. The focus of the EQRO SSI Care Management Review process is to ensure HMO compliance with the SSI Care Management requirements defined in Art. III of the 2018 BC+ and Medicaid SSI HMO Contract.

EQRO Review	2018-19	2020-21	EQRO frequency
<p>Care Plan Development - EQRO will create a sample per HMO of members with the G9001 code in the CY and request care management records for the members in the sample. EQRO will focus on assessing whether or not HMOs are complying with the Care Plan development requirements in Art. III, section B.3.d of the 2018 BC+ and SSI HMO Contract.</p>			
<p>a. Is the Care Plan developed based on a screening conducted within 60 days of the member's enrollment in the HMO?</p> <p>b. Is the Care Plan an evidence-based plan of care that:</p> <ul style="list-style-type: none"> • Identifies the member's needs including: <ul style="list-style-type: none"> i. Formal and informal supports ii. Chronic conditions and acute illnesses iii. Mental and behavioral health conditions iv. Dental care needs v. Medications taken by the member; any concerns with member's understanding and use of medications vi. Additional supports needed to conduct activities of daily living or instrumental activities of daily living vii. Social determinants of health (Yes/No). • Defines specific goals that the member wants to achieve and that are appropriate to address his/her needs (Yes/No). • Evidence that HMO has a system to prioritize member's goals appropriately, based on urgency, member's engagement and their impactability (Yes/No). 	x	x	Annual

EQRO Review	2018-19	2020-21	EQRO frequency
<ul style="list-style-type: none"> Describes the interventions that will be implemented to address the member's needs and their sequence (Yes/No). 			
<p>WICT – EQRO will pull a sample per HMO of members with TG modifier from codes G9002, G9006, G9007 and G9012 billed during the CY. To answer the questions below, the EQRO will request the HMO's WICT policies and procedures, care management records for the member's in the sample, and WICT meeting minutes. EQRO will focus on assessing whether or not HMOs are complying with the Care Plan development requirements in Art. III, section B.3.d of the 2018 BC+ and SSI HMO Contract.</p>			
<p>a. Well-functioning WICT - Is there evidence of a well-functioning interdisciplinary team:</p> <ul style="list-style-type: none"> With at least 2 health care professionals with access to expertise across multiple areas (MD, pharmacist, BH, social work, social determinants of health etc.)? (Yes/No) With a WICT Core Team that meets weekly to discuss their entire shared case load? (Yes/No) With a WICT Core Team that coordinates regularly with the member's PCP, medical specialists, behavioral health specialists, dental providers, and other community resources as driven by the member's care plan? (Yes/No) 	x	x	Annual
<p>b. Face-to-face requirement – Is there evidence in the member's Care Plan that the WICT Core Team (a licensed healthcare professional or other WICT team member meeting weekly and sharing a caseload) or the member's community-based care manager, that is also a WICT team member (e.g., community health worker), meet at least once a month face-to-face with the member to discuss a need identified in his/her care plan? (Yes/No)</p> <p><i>Note: A WICT member's face-to-face meeting with their community based case manager (e.g., Comprehensive Community Services or Community Support Programs case manager) may meet the face-to-face requirement if the community based case manager has a close, collaborative relationship with the WICT Core Team that is demonstrated in the member's care plan and includes reciprocal</i></p>	x	x	Annual

EQRO Review	2018-19	2020-21	EQRO frequency
<p><i>communication between the WICT Core Team and the community based case manager.</i></p> <p><i>The face-to-face visit must be documented as a care coordination and monitoring activity in the member's care plan to be deemed as met.</i></p> <p><i>The EQRO will look for evidence in the member's care plan and care management notes.</i></p> <p><i>The EQRO will also describe who within the WICT is conducting the meetings and the meeting location (i.e., meeting at the member's home or meeting the member elsewhere).</i></p>			
<p>c. Graduation –</p> <ul style="list-style-type: none"> • Does the member's Care Plan clearly identify the criteria for the member to graduate from the WICT? (Yes/No) • Is there evidence of the WICT being a short-term (i.e., less than 12 months) intensive intervention? (Yes/No) • Once the member is ready to graduate from the WICT, is there evidence that the WICT is coordinating the transition of members to a lower intensity of care management? (Yes/No) 	x	x	Annual
<p>Care Management Service Delivery – <i>EQRO will create a sample per HMO of members with the G9001 and G9002 codes billed during the CY which will be stratified by low, medium, high using the TG and TF modifiers. EQRO will look for evidence in the care management records of member's in the sample to address the questions below.</i></p>			
<p>a. Compliance with the Care Plan - Are services, including any planned follow-ups with members, delivered according to the Care Plan?</p>	x	x	Annual
<p>i. Member-centric Care</p> <ul style="list-style-type: none"> ○ When implementing the Care Plan, does the HMO regularly assess the member's readiness to change and their level of engagement in meeting their Care Plan goals? (Yes/No) ○ As part of Care Plan implementation, is there evidence that the HMO is adhering to its 	x	x	Annual

EQRO Review	2018-19	2020-21	EQRO frequency
<p>own policies and procedures regarding frequency of contact with members per strata?</p> <ul style="list-style-type: none"> ○ Is there evidence that the HMO is asking members if their needs are being addressed? (Yes/No) 			
<p>ii. Social Determinants (SD):</p> <ul style="list-style-type: none"> ○ Is follow-up on SD documented in the Care Plan? (Yes/No) ○ Did the HMO go beyond simple referrals and beyond sharing phone numbers for community resources with the member? (Yes/No) <p><i>EQRO will describe HMO efforts to address social determinants including how they are working collaboratively with community resources or utilizing Community Health Workers.</i></p>	x	x	Annual
<p>iii. Behavioral Health</p> <ul style="list-style-type: none"> ○ Does the HMO follow-up to address the member's behavioral health needs identified in the Care Plan? (Yes/No) 	x	x	Annual
<p>Care Plan Review & Update – <i>EQRO will create a sample per HMO of members with G9001 and G9002 codes billed during the CY. The EQRO will also review the HMO's care management policies and procedures as well as the member's care management records to assess compliance with the review and updates to the Care Plan requirements defined in Art. III, B. 3.e of the 2018-2019 BC+ and SSI HMO Contract.</i></p>			
<p>a. Is the HMO reviewing and updating the Care Plan based on the criteria defined in Art. III, B. 3.e of the 2018-2019 BC+ and SSI HMO Contract?</p> <ul style="list-style-type: none"> ● At least once per calendar year (Yes/No) ● According to the HMO's policies and procedures for reviewing Care Plans and re-stratifying members (Yes/No) ● Whenever the member is not responsive to the Care Plan or whenever the member frequently transitions between care settings (Yes/No). 	x	x	Annual

EQRO Review	2018-19	2020-21	EQRO frequency
b. Does the HMO re-stratify members after critical events, as appropriate? (Yes/No)	x	x	Annual
Discharge Follow-up / Transitional Care – EQRO will create a sample per HMO of SSI members with G9012 code billed during the CY and review their care management records to determine compliance with the transitional care contract requirements.			
<p>a. Did the HMO’s transitional care follow-up meet the transitional care requirements in Art. III, B. 3.f of the 2018-2019 BC+ and SSI HMO Contract?</p> <ul style="list-style-type: none"> • How was the HMO notified of the member’s hospital admission? • Was the follow-up in-person, via interactive video, or over the phone? • Is there evidence that the transitional care follow-up included: <ul style="list-style-type: none"> i. Medication reconciliation, documented in the member’s care management notes, conducted either by the hospital or the HMO. ii. A review with members of (a) the discharge information prepared by the hospital and (b) the member’s medications and their medication schedule. • Did the HMO assist members with scheduling appointments with other health care providers after discharge? (Yes/No) <p><i>The EQRO will describe if the HMO is receiving real-time notifications about the member’s hospital admission and if the HMO is using WISHIN or EPIC Care Everywhere for transitional care. The EQRO will also describe how the HMO is conducting the follow-up and assess whether the HMO is helping members scheduling follow-up appointments, understand their medication schedule and their treatment plan.</i></p>	x	x	Annual

V. Potentially Preventable Readmissions (PPR)

1. Goal of the HMO PPR Initiative

To reduce Potentially Preventable Readmissions (PPRs) for Wisconsin Medicaid members served by HMOs.

Excess readmission chains relative to benchmarks suggest an opportunity to improve patient outcomes and to reduce costs through better discharge planning, better coordination of care across sites of service, and/or other improvements in the delivery of care.

2. PPR Software

PPR calculation is based upon a clinical algorithm create by 3M's physician and nursing staff. 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.

For all Wisconsin Medicaid inpatient HMO claims, only 4.5% of Qualifying Admissions were followed by an RA in SFY2016.

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 the Department's focus is on the impact of HMO-specific initiatives with their providers, recognizing that there will be variation across providers and HMOs. Readmission chain rates for Fee-for-Service (FFS) hospitals will be calculated using only

the FFS data. All FFS hospitals are included in FFS PPR calculations, though only providers with over 25 qualifying admissions are eligible to participate in the FFS incentive program.

- d. 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 the Department's vendor, Navigant, has not shown a variation in the ABRs across the Medicaid rate regions.
- e. 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 DHS to compare HMO performance even when there are differences in enrollment, population morbidity, inpatient volume, and inpatient case mix. Examples of risk adjustment were shared with the HMOs via email on November 14, 2017.
- f. 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.
- g. PPR calculations for an HMO are based on all providers serving the Medicaid members of that HMO. Since the HMO PPR initiative for MY2018 is "up-side only", there are no minimum thresholds re: # of Qualifying Admissions for HMOs.
- h. 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 (similar to recipients switching hospitals for hospital PPR chain). However, such instances are rare - a Department analysis found that less than 0.5% of HMO PPR chains involved a switch between HMOs by a member.
- i. Transfer of patients across facilities: All transfers across facilities are handled in a similar manner, regardless of diagnoses (e.g., behavioral health, others). Please refer to the PPR training slides (#12-16) from the May 4, 2017 HMO Technical Call. Additional background slides are attached at the end of this document.
- j. 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 the Department. The Department will be open to reviewing at a later date how social determinants data submitted by HMOs can be used in PPR calculations.
- k. For PPR related to SSI Care Management PIPs only: When a patient who has previously not had an upfront screening (i.e., no G9001 code billed yet for that year) is so identified

while being admitted for inpatient care, it presents an opportunity to conduct the upfront screening (G9001 billing code) and to provide transition care services (G9012 code). Both the codes cannot be billed in the same month even though both services can be provided in the same month in this scenario. The Department will track such service events. The HMOs are also expected to track such service events separately, and to bring them to the Department's attention in a timely manner. HMOs will have an opportunity to review the preliminary results from the Department, and provide feedback to the Department if such services are missed in the calculations.

- I. An HMO may dispute the Department's PPR calculations by sending a written communication to the Department's Quality team within the Bureau of Benefits Management, no later than 30 days after receiving the Department's PPR calculations. After 30 days, the HMO waives the right to dispute the PPR calculations. Any dispute communication should be accompanied by supporting documentary evidence that shows how the HMO's PPR calculations are different than the Department's calculations.

4. HMO PPR Initiative

a. Population in scope:

MY2018 HMO PPR initiative will focus on BadgerCarePlus readmissions only. SSI readmission chains account for about 8% of HMO readmission chains state-wide, are different than the readmission chains for BC+, and could vary in the future as more SSI members are served through Managed Care. Therefore, the SSI HMO readmissions will be addressed through SSI Care Management (Needs Stratification) PIPs in 2018.

a. 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 *N* in the HMO PPR report shared by the Department with the HMOs.

Numerator = Readmission rate, shown in row *I* in the HMO PPR report

Denominator = Benchmark readmission rate, shown in row *M* in the HMO PPR report.

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

b. Baseline for 2018:

DHS will calculate the HMO-specific ABR baselines for Measurement Year (MY) 2018 using FFY2016 data, 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.

c. Upside incentives:

For MY2018 (January 1 – December 31), HMOs will have an up-side incentive only, with no PPR-related penalties. The Department will set aside a pool of up to \$9 million as up-side only incentive, to be distributed among HMOs that meet their targets for % reduction in their ABR, as value-based payments. HMOs that do not meet the target will not receive any PPR incentive funds.

For MY2018, the FFS PPR initiative is funded by a 5% withhold applicable to 2018 payments to the FFS providers only; there is no corresponding PPR withhold for HMOs. In future years the initiative may include an up-side (bonus) and down-side (penalties) arrangements, in alignment with the FFS PPR initiative for hospitals.

Note: Per 42 CFR 438.6(b)(2), "...Contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound...". The 105% limitation will be applicable cumulatively across various incentives such as P4P and PPRs.

d. Departmental guidance to HMOs:

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

e. Methodology for targets and incentives:

Each HMO will be eligible to earn a pro-rated 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.

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

- Tier 1 = High performance HMOs, with baseline ABR ≤ 0.95 ;
- Tier 2 = Middle performance HMOs, with baseline ABR ≥ 0.96 but ≤ 1.05 ;
- Tier 3 = Low performance HMOs, with baseline ABR ≥ 1.06 .

The Tiers above also create confidence intervals for the methodology.

The Department plans to use a consistent definition of PPR and APM in MY2018 and MY2019. Over time, the Department will track and may adapt the targets, results and its PPR methodology, as appropriate.

HMOs with low ABR (≤ 0.85):

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

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

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>
1.00	5% or more	7% or more	10% or more
0.75	3% to 4.9%	4% to 6.9%	7% to 9.9%
0.50	1% to 2.9%	2% to 3.9%	4% to 6.9%
0.25	0.25% to 0.9%	0.5% to 1.9%	1.5% to 3.9%

Interpreting the "PPR Reduction Targets" table:

- First, identify the tier in which an HMO was placed, based on its baseline year ABR.
- Next, 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".

- Next, identify the proportion of the Potential Incentive Share that is earned by the HMO based on its % reduction in ABR, by looking left in the first column.
 Example: A Tier 1 HMO with a 6% reduction in ABR would earn its full potential incentive share (earned proportion = 1.00, or 100%).
 Alternatively, if that HMO reduced its ABR by, e.g., 3.5% instead of 6%, it would earn 0.75 proportion (=75%) of its potential incentive share; if that HMO reduced its ABR by, e.g., 0.7%, it would earn 0.25 proportion (=25%) of its potential incentive share.

Illustrative example - HMO PPR methodology (hypothetical data)

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

HMO PPR HYPOTHETICAL EXAMPLE									
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8	Col. 9	Col. 10
HMO	Qualifying admissions in Baseline Year	Share of qualifying admissions	Potential Incentive share	Baseline ABR	Tier in baseline year	MY ABR	% reduction from baseline	Potential Incentive earned	\$ Incentive earned
A	70,000	32.6%	\$1,627,907	1.090	Low	0.950	12.84%	100%	\$1,627,907
B	20,000	9.3%	\$465,116	1.030	Middle	0.970	5.83%	75%	\$348,837
C	100,000	46.5%	\$2,325,581	1.040	Middle	1.070	-2.88%	0%	\$0
D	15,000	7.0%	\$348,837	0.940	High	0.920	2.13%	50%	\$174,419
E	10,000	4.7%	\$232,558	0.840	High	0.850	-1.19%	100%	\$232,558
State-wide	215,000	100.00%	\$5,000,000	1.000			3.53%	43%	\$2,151,163

- Column 3 shows the relative share of each HMO in the total qualifying admissions in the baseline year. E.g., HMO A has 70,000 / 215,000 = 32.6% share.
- Assume the Department sets aside \$5 million as the total incentive pool (shown in the last row for Col. 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 32.6% of \$5 million = \$1,627,907.
- Hypothetical baseline ABR for each of the 5 HMOs are shown in Column 5.
- Column 6 shows the tier in which each HMO is placed, based on its baseline ABR.
- Column 7 shows the ABR achieved in the Measurement Year (MY).
- Column 8 shows each HMO's % ABR reduction = (Column 5 – Column 7) / Column 5.
- Column 9 shows the % of the Potential Incentive earned, based on the "PPR Reduction Targets" table, discussed above.
 For example, HMO A earned 100% of its Potential Incentive \$, while HMO D earned 50% of its Potential Incentive. HMO E earned 100% of its potential share because its ABR was <= 0.85 for both, the baseline year and the MY, regardless of its reduction in ABR.

- Column 10 shows the \$ value of incentive earned (= Column 9 * Column 4).

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

PPR incentive payments for MY2018 will occur in 2019, after data for full MY2018 are available and have been analyzed.

f. Sharing the incentives with Providers and alignment with APM:

- HMOs may keep up to 15% of PPR incentive earned for their administrative expenses. The remaining incentives must be shared with their providers, including hospital and non-hospital providers. PPR bonus \$ that are earned and then shared by HMOs with their providers (hospital and non-hospital) can be counted as APM (Alternative Payment Model) dollars, and be added to the APM numerator, in support of the Department's APM initiative for MY2018. HMOs are welcome to discuss with the Department their specific ideas re: gain sharing with their providers.
- HMOs will have flexibility in negotiating how they share incentive dollars with their providers. The Department believes that the HMOs' interest in ensuring a hospital is not penalized by one HMO while being rewarded by another, would 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 MY2018, 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. Such expenses can also be counted towards the APM numerator. HMOs can count the actual hours (and related dollars) worked by their internal teams on PPR reduction, as provider sharing for MY2018. HMOs will be required to maintain adequate supporting documentation for such time and dollars, and share it with the Department if requested. HMOs will be asked to attest to the accuracy of such dollars. HMOs are welcome to discuss their plans for establishing internal teams with the Department.

g. 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 the Department from sharing grouped PPR claims with plans. PPR software can be purchased from 3M using default settings, grouper version 32.

The Department intends to share three types of PPR reports with HMOs, to balance the timeliness and completeness of such reports (also see the table below):

1. **Working data reports:** HMOs will receive “working data” reports about 6 weeks after the end of a measurement period (e.g., a quarter). Working data reports are meant to provide recent information to HMOs, while recognizing that such reports will have incomplete data because not enough “claims run-out” time would have passed since the end of the measurement period.
2. **Preliminary annual reports:** HMOs will receive “preliminary” annual reports about 4.5 months after the end of the measurement year (MY2018 = Jan 1 – Dec 31, 2018). 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. M
3. **Final annual reports:** HMOs will receive the “final” annual reports about 7.5 months after the end of the MY. HMOs will have the opportunity to provide feedback to the Department between receiving the preliminary annual reports and the final annual reports. Any PPR-related incentives will be calculated based on the final annual reports.

Measurement period	Working data available on:	Preliminary annual report available on:	Final annual report available on:
2018			
1/1 – 3/31	5/15/2018	N/A	N/A
4/1 – 6/30	8/15/2018	N/A	N/A
7/1 – 9/30	11/15/2018	N/A	N/A
10/1 – 12/31	2/15/2018	N/A	N/A
2019			
1/1 – 3/31	5/15/2019	5/15/2019 (data for MY2018)	N/A
4/1 – 6/30	8/15/2019	N/A	N/A
7/1 – 9/30	11/15/2019	N/A	8/15/2019 (data for MY2018)
10/1 – 12/31	2/15/2019	N/A	N/A
2020			
1/1 – 3/31	5/15/2020	5/15/2020 (data for MY2019)	N/A
4/1 – 6/30	8/15/2020	N/A	N/A
7/1 – 9/30	11/15/2020	N/A	8/15/2020 (data for MY2019)
10/1 – 12/31	2/15/2021	N/A	N/A

WISCONSIN DHS READMISSION BENCHMARK CALCULATION

OCTOBER 18, 2017

Confidential and Proprietary

NAVIGANT

READMISSION BENCHMARK CALCULATION

Readmission Benchmark Calculation Steps

- Determining the Potentially Preventable Readmission (PPR) benchmark for an HMO involves the following steps:

Using statewide managed care data:

1. Process statewide managed care encounters using the 3M PPR software, which classifies each admission as follows based on the APR DRG:
 - Only Admission (OA), not followed by a PPR within 30 days
 - Initial Admission (IA), followed by a PPR within 30 days
 - Potentially Preventable Readmissions (RA), following an IA within 30 days
 - Excluded, based on the PPR clinically based algorithm (ex: clinically complex)
2. For each combination of APR DRG and severity of illness (SOI) level, calculate the statewide average readmission rate (based on IAs divided by sum of OAs and IAs)

Using HMO-specific managed care data:

3. Multiply the HMO's number of APR DRG/SOI claims times the statewide average readmission rate for each APR DRG/SOI combination to determine an HMO's initial readmission benchmark
4. Apply additional adjustments to account for differences in readmission rates for mental health and pediatric services to determine an HMO's final readmission benchmark

READMISSION BENCHMARK CALCULATION

Readmission Benchmark Calculation Approach

- Readmission benchmark methodology establishes a standard readmission rate for each service which serves as the basis for the performance measurement for HMOs
 - “Actual-to-Benchmark Ratio” calculated by dividing actual readmissions by benchmark readmissions
 - Actual readmissions that exceed benchmark readmissions (ratio greater than 1.0) are considered “excess” for performance measurement purposes
- Readmission benchmarks factor in differences in volume and service mix (both in terms of case mix and pediatric and mental health patient mix) to allow for meaningful comparison across HMOs and regions
 - Greater utilization and/or a greater proportion of services with higher readmission rates will be reflected in a HMO’s readmission benchmark

READMISSION BENCHMARK CALCULATION

Readmission Benchmark Example (Not Actual Figures)

APR DRG	DRG Description	Statewide Average Readmission Rate	HMO Plan 1		HMO Plan 2	
			Qualifying Admissions	Benchmark Readmissions	Qualifying Admissions	Benchmark Readmissions
A	B	C	D	E = D x C	F	G = F x C
023-3	SPINAL PROCEDURES	22.2%	5	1.11	1	0.22
045-2	CVA & PRECEREBRAL OCCLUSION W INFARCT	1.1%	2	0.02	6	0.07
054-3	MIGRAINE & OTHER HEADACHES	20.0%	6	1.20	3	0.60
115-1	OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES	4.5%	2	0.09	5	0.23
Total Benchmark Readmissions			15	2.42	15	1.12
Actual Readmissions			15	1	15	3
Actual Readmissions Over/(Under) Benchmark Readmissions				(1.42)		2.88
Actual-to-Benchmark Ratio				0.413		2.679

VI. Alternative Payment Models (APM)

1. Goal of the APM Initiative

The Department's APM program goals are aligned with Learning Action Network (LAN)'s goals to move "payments away from Fee-for-Service (FFS) and into APMs that reduce the total cost of care (TCOC) and improve the quality of care."

2. Definition of APM

The Department defines APMs as payments made by Wisconsin Medicaid HMOs to their providers through quality and value-based purchasing arrangements. Providers include non-hospital providers (community based providers, and home health agencies, among others) and hospitals. The initiative does not require HMOs to make payments to providers who do not demonstrate quality improvements.

The APM **denominator** is the total payments by Wisconsin HMOs to their providers for services rendered to BadgerCarePlus and Medicaid SSI members. The denominator *includes* any APM-related payments.

The APM **numerator** is the total dollar value of all payments that could potentially be made by Medicaid HMOs to their providers for services rendered to BadgerCarePlus and Medicaid SSI members, that are directly linked to attainment of quality goals by the providers, or, alternatively stated, are "at-risk" for quality achievements.

Example: If an HMO pays \$1 million as FFS reimbursement to its providers for services rendered, and the providers are eligible to receive another \$50,000 for achieving specific quality targets, then the APM numerator = \$50,000, the denominator = \$1,050,000, and the APM ratio = 4.76%.

The numerator **includes** (but is not limited to):

- a. Capitation payments that could be made by HMOs to their providers for which the providers assume the full insurance risk, without back-end reconciliation, even if these payments are not based on / connected to quality;
- b. Capitation payments with back-end reconciliation that are connected to quality;
- c. Payments to providers for improving identification, communication and management of, e.g., high risk pregnancies (e.g., through OB Medical Home), weight management, smoking cessation initiatives, etc.;
- d. Payments to providers for specific activities (including those through PIPs) that lead to improvement in preventive and chronic condition care as reflected by P4P, Core Reporting and other quality measures;
- e. Dollars from HMO PPR incentives earned by HMOs that are shared with providers. Please see the HMO PPR section of the MY2018 Quality Guide (the "Guide") for further details;

- f. Amounts expended by HMOs on their internal staff (clinical and non-clinical) for activities directly related to PPR reduction, e.g., discharge planning, medication reconciliation on discharge, follow-up in out-patient settings following discharge, home visits, etc. Please see the HMO PPR section of the MY2018 Quality Guide for further details;
- g. Payments made by HMOs above the FFS contracted rate; only the payment dollars that are above the FFS contracted rate and are tied to quality should be included in the APM numerator.

The numerator does NOT include:

- a. Any surplus or profit sharing by HMOs with the providers if such sharing is not directly related to attainment of quality goals by the providers;
- b. The base payments, not at risk, for services.
Example: If an HMO pays \$10 million to providers for services rendered (base payments, not at risk) and the provider could earn up to another \$0.5 million by meeting quality targets, the numerator will include \$0.5 million, not the \$10 million.

3. Scope and Features

- a. Measurement Year (MY) 2018 will be from January 1 through December 31, 2018.
- b. The scope includes BadgerCare Plus (this includes the Childless Adult population) and Medicaid SSI Plan, as described in the Guide. APMs are applicable across the State of Wisconsin, i.e., all six Medicaid HMO rate regions.
- c. HMOs are required to report the potential dollars for the APM-related numerator and denominator, and the percentage of their potential total payments to providers that were based on quality and value-based payments, annually. HMOs will be asked to attest to the accuracy of their submissions.
- d. There are no HMO withholds or incentives for APM performance in MY2018.
- e. The Department plans to use a consistent definition of APM in MY2018 and MY2019.
- f. The Department recognizes different perspectives on this initiative, and that the Department and the HMOs will learn together about collaboration opportunities and challenges in implementing such initiatives for provider-owned and non-provider owned HMOs. The Department's HMO PPR and APM initiatives are related, and the Department would like to see HMOs develop their plans to reduce PPRs jointly with their providers; HMOs may also choose to collaborate with other HMOs to identify joint focus areas to reduce PPRs with common providers.
- g. The Department is considering publicly reporting APM data for HMOs.

4. MY2018 APM Threshold Target

The Department has set a **10% threshold target** for combined BadgerCarePlus and Medicaid SSI dollars for MY2018. HMOs will need to execute APM-related contracts with their providers by December 31, 2018 in order for the potential APM payments to be counted in the numerator by December 31, 2018.

5. Alignment with HMO PPR initiative

HMOs may keep up to 15% of PPR incentive earned for their administrative expenses. The remaining incentives must be shared with their providers, including hospital and non-hospital providers. PPR bonus \$ that are earned and then shared by HMOs with their providers (hospital and non-hospital) can be counted towards the APM numerator.

6. Shared Savings arrangements

HMOs may also set up “shared-savings” arrangements with their providers, either as part of or outside the HMO PPR initiative. An HMO may include such potential savings in the APM numerator IF such savings are clearly discussed in the HMO's written contracts with its providers. For instance, if an HMO enters into shared-savings arrangements with its providers, the HMO could create a reasonable estimate of the total \$ value of the potential savings with its providers in the coming year, and determine in advance the % of such savings the HMO would share with its providers, as shown in the hypothetical example below.

- An HMO might establish a savings target of \$75 PMPM with a provider for MY2018, and agree to share 75% of the resulting savings.
- Assume the provider serves 1,000 Medicaid members of that HMO.
- It might be reasonable for the HMO to assume that while the target was set at \$75 PMPM, the actual savings might be between \$30 and \$50 PMPM. Assume an average of \$40 PMPM in anticipated savings.
- Given the above assumptions, the provider might expect to receive in “shared savings”:
= \$40 (anticipated PMPM savings) * 1,000 members * 75% share in savings * 12 months
= \$360,000.
The \$360,000 can be added to the APM numerator by the HMO.

“Two x” credit for Shared Savings:

The Department encourages HMOs to establish shared savings arrangements with their providers, and also recognizes the complexities in establishing such shared savings models. Therefore, for MY2018, HMOs may add to the APM numerator **two times** the value of potential shared savings dollars. In the above example, if the HMO calculates the estimated value of shared savings to be \$360,000, it can add $(2 \times \$360,000) = \$720,000$ to its APM numerator.

VII. Health Needs Assessment Guide

The following HNA Guide was shared by DHS with the HMOs via email on Dec 22, 2017. Please click on the icon below to open the Microsoft Word document.



2018 HNA Guide
for HMOs

VIII. HealthCheck Specifications

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

Measure Description:

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

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

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

Codes

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

- Procedure Codes:

CPT – 4 Codes: Preventive Medicine Services *

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

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

CPT – 4 codes: Evaluation and Management Codes**

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

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

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

Work Sheet:

DHS will use the HealthCheck worksheet below to measure compliance with the 80% target of HealthCheck comprehensive visits in the 2018 BadgerCare Plus and Medicaid SSI HMO Contract. An HMO that does not meet the target will be subject to one penalty, combined, for BadgerCare Plus and SSI contracts.

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

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

Explanation of the HealthCheck Worksheet

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

Anchor Date for the measure: December 31 of the measurement year.

- Row #2: # of unique, unduplicated members in the eligible population.
- Row #3: Expected # of screens for an individual member in each age group, based on CMS recommendations / specifications.

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

HealthCheck Worksheet EXAMPLE:

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

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

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

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